Approved by: Charles Slowey, a/Associate Vice-President
Approved by: Jacques Cloutier, Vice-President, Operations Branch

Date: April 24, 2018
Classification: Protected B

ISSUE SHEET

DEATHS IN CUSTODY

Suggested Speaking Bullets:

- The Canada Border Services Agency (CBSA) is committed to creating a better, fairer system for the humane and dignified treatment of individuals while upholding public safety.
- When a death in custody occurs, the Agency fully cooperates with all investigations that are undertaken.
- In August 2016, the Government of Canada announced $138 million for a National Immigration Detention Framework that will:
  - enhance alternatives to detention;
  - significantly improve conditions at federal Immigration Holding Centres in Vancouver, Toronto and Laval, including better access to on-site medical and mental health services; and,
  - reduce reliance on provincial facilities where high risk detainees are held.
- These measures are meant to mitigate the risk of serious incidents, such as deaths in custody.

Issue:

Since 2003, there have been **13 deaths in CBSA custody**: three suicides, five natural causes, one homicide, and four cases that are still subject to ongoing investigation.

Background:

The CBSA's quality assurance program, along with internal and external audits and evaluations, ensures that it consistently adheres to national detention standards and international protocols.

On July 27, 2017, a contract was awarded to the Canadian Red Cross (CRC) for the monitoring of immigration detainees held in detention facilities across Canada to ensure that they are treated in compliance with applicable domestic standards and international obligations to which Canada is signatory. The CRC will conduct immigration detention monitoring services as a reputable third-party organization by visiting detention facilities across Canada (CBSA-managed Immigration Holding Centres (IHC) and provincial correctional facilities) and interviewing immigration detainees who are being held pursuant to *Immigration and Refugee Protection* Act. Monitoring includes up to 86 visits over a two-year period (to July 2019) to facilities across Canada, primarily focusing on the most vulnerable including unaccompanied minors and individuals with medical and mental health conditions. The CRC is required to report on its monitoring activities and the CBSA is committed to publishing the CRC's annual national report (which will include a summary of yearly monitoring activities, findings and recommendations), and its management action plan in response to CRC's recommendations.

At the same time, the CBSA regularly consults stakeholders and NGOs, such as the UNHCR, about detention issues and takes their recommendations into account.

The CBSA assesses incidents to determine whether appropriate policies, guidelines and directives have been adhered to and what remedies may be required. After Incident Reports may include a management action plan to address the report's recommendations. The working group reports to the President and ensures full implementation of management action plans.

The 2016 National Immigration Detention Framework committed $138M over five years and on-going funding to:

- Undertake infrastructure replacement and retrofits at three IHCs;
- Expand availability of alternatives to detention, including the ability to report by phone through voice recognition technology rather than in-person;
- Develop partnerships, including arrangements with community-based organizations to deliver alternatives to detention and with provinces to standardize and improve the treatment of those detainees that will continue to be held in provincial facilities;
- Develop and implement risk-based national policies and detention standards with an immediate focus on minors, long-term detention and mental health to improve detainee well-being;
- Expand medical and mental health support in the IHCs; and,
- Ensure greater openness, accountability and transparency in the delivery of the immigration detention program.

Current Status:

The most recent inquest was in May 2016 for Joseph Charles Todd Dunn, who was held in the Niagara Detention Centre (Thorold, ON).

The CBSA has not been informed of inquests related to the death in custody of Abdurahman Ibra, Hassan (2015); (2016); Francisco Javier Romero Astorga (2016); Peter Tut Khor (2016); and, Teresa Michelle Gratton (2017). Refer to the enclosed chart for additional detail.

PROTECTED B:

The chart below includes names that are not in the public domain. The Canada Border Services Agency only provides the name of a deceased detainee with the approval of the next-of-kin or if another authority releases the name publicly.

	Name	Date of death	Cause of Death	Detention Location
1		15-Sep-04	Unknown	Centre de Détention, Rivière-des-prairies, Montreal
2	Jan **SZAMKO**	08-Dec-09	Natural Causes	Toronto West Detention Centre (coroner's inquest)
3	Kevon **O'BRIEN-PHILLIP**	02-Jan-10	Homicide	Toronto Don Jail
4		26-Aug-10	Natural Causes	Laval Detention Centre
5	Shawn Dwight **COLE**	26-Dec-12	Natural Causes	Toronto East Detention Centre
6		05-Mar-13	Natural Causes	Toronto West Detention Centre
7	Lucia **VEGA JIMENEZ**	28-Dec-13	Suicide	Vancouver Immigration Holding Centre (coroner's inquest)
8	Joseph Charles Todd **DUNN**	27-Sep-14	Suicide	Niagara Detention Centre, Thorold
9	Abdurahman Ibra, **HASSAN**	11-Jun-15	Unknown	Peterborough Hospital
10		07-Mar-16	Suicide	Toronto East Detention Centre
11	Francisco Javier **ROMERO ASTORGA***	13-Mar-16	Natural Causes	Maplehurst Correctional Complex
12	Peter Tut **KHOR**	14-May-16	Unknown	Edmonton Remand Centre
13	Teresa Michelle **GRATTON**	30-Oct-17	TBD	Vanier Centre for Women

**This individual was not under CBSA care and custody at the time of incident. Immediately following the incident CBSA incorrectly assessed that he was in CBSA custody.*

Approved by: Martin Bolduc, Vice President, Programs Branch
Approved by: Caroline Xavier, Vice-President, Operations Branch

Date: February 24, 2017
Classification: UNCLASSIFIED

ISSUE SHEET

DEATHS IN CUSTODY

Suggested Speaking Bullets:

- The Government of Canada is aware of concerns about the immigration detention system. The CBSA is committed to creating a better, fairer system for the humane and dignified treatment of individuals while upholding public safety.
- When a death in custody occurs, an investigation is undertaken and the Agency fully cooperates in the investigation surrounding the case.
- In August, the Government of Canada announced a $138 million new National Immigration Detention Framework (NIDF) that will enhance alternatives to detention, significantly improve conditions at federal Immigration Holding Centres in Vancouver, Toronto and Laval, and reduce reliance on provincial facilities where high risk detainees are held.
- Additional funding has been provided in the Framework to increase the level of access to on-site medical and mental health services at the three holding centres, such as nursing services, physician care, as well as, psychological and/or psychiatric support.
- These measures are meant to mitigate serious incidents, such a death in custody.

Context:

Issue:

Since 2003, there have been **12 deaths in CBSA custody**: three suicides, four natural causes, one homicide; and three cases subject to ongoing investigation

Background:

The CBSA strives to maintain the highest national standards for program integrity and oversight of its detention program. The CBSA's quality assurance program, along with internal and external audits and evaluations, ensures it consistently strives to meet national detention standards and international protocols.

The Canadian Red Cross monitors CBSA compliance with national and international standards pursuant to a 2006 Memorandum of Understanding. The CRC regularly visits detention facilities (IHCs and provincial facilities) to monitor the treatment of detainees (by staff or other detainees); conditions of detention; ability for detainees to contact and maintain contact with family members; and legal safeguards. In 2013-14, the Red Cross carried out a total of 49 detention monitoring visits nationwide including 30 visits to provincial detention facilities.

The Red Cross encourages improvements to detention conditions and promotes the rights of detainees. At the same time, the CBSA regularly consults stakeholders and NGOs, such as the UNHCR, about detention issues and takes their recommendations into account as a means of continuously improving detention conditions.

The CBSA's Incident Management Working Group assesses whether appropriate national policies, guidelines and directives have been adhered to in relation to the incident and what remedies, if any, may be required. This assessment is delivered in the form of an After Incident Report, and may include a management action plan to address the report's recommendations. The working group ensures full implementation of the management action plans, and reports to the President.

Lastly, the 2016 National Immigration Detention Framework committed to $138 million, over five years and on-going funding, to transform the immigration detention system.

Initiatives under the Framework include:

- infrastructure replacement and retrofits at three Immigration Holding Centres;
- expanding the availability of Alternatives to Detention (ATDs) nationally, including the ability to report by phone through voice recognition technology to minimize the need to report to the CBSA in person, maximize freedom of movement, facilitate compliance and optimize efficiencies;
- developing partnerships for the delivery of the immigration detention program, which include arrangements with community-based organizations to deliver the expanded ATD program; and the signing of provincial agreements for the detention of the highest risk individuals to standardize and improve treatment of those detainees that will continue to be held in provincial facilities;
- developing and implementing risk-based national policies and detention standards with an immediate focus on minors, long-term detention and mental health to improve detainee well-being;
- expanding medical and mental health support in the IHCs; and
- ensuring greater openness, accountability and transparency in the delivery of the immigration detention program.

Current Status:

The most recent inquest was in May 2016 for Joseph Charles Todd Dunn, who was held in the Niagara Detention Centre (Thorold, ON).

The CBSA has not been informed about inquests for the four subsequent deaths in custody, namely for Abdurahman Ibra, Hassan (2015), (2016), Francisco Javier Romerao Astorga (2016), and Peter Tut Khor (2016); refer to the enclosed chart.

Date: March 9, 2016
Classification: Protected B

This document contains information protected by the Privacy Act. It is not to be shared with anyone who does not have a "need to know".

BACKGROUNDER
(DEATH OF A CANADA BORDER SERVICES AGENCY DETAINEE WHILE IN CUSTODY – MARCH 2016)

Issue

Suicide of a Canada Border Services Agency (CBSA) client while under the care and control of the Toronto East Detention Centre.

Background

	Name	Date of death	Cause of Death	Detention Location
1		15 Sep 2004	Natural Causes	Centre de Détention, Rivière-des-Prairies, Montréal (provincial)
2	Jan **SZAMKO**	08-Dec-09	Natural Causes (coroner's inquest)	Toronto West Detention Centre (Provincial)
3	Kevon **O'BRIEN-PHILLIP**	02-Jan-10	Homicide	Toronto Don Jail (Provincial)
4	Shawn Dwight **COLE**	26-Aug-10	Natural Causes	Laval Detention Centre (CBSA)
5		26-Dec-12	Natural Causes	Toronto East Detention Centre (Provincial)
6		05-Mar-13	Natural Causes	Toronto West Detention Centre (Provincial)
7	Lucia **VEGA JIMENEZ**	28-Dec-13	Suicide (coroner's inquest)	Vancouver Immigration Holding Centre (CBSA)
8	Joseph Charles Todd **DUNN**	27-Sep-14	Suicide	Niagara Detention Centre, Thorold (Provincial)
9	Abdurahman Ibra, **HASSAN**	11-Jun-15	Ongoing investigation	Central East Correctional Centre Died in Peterborough Hospital (Provincial)
10		07-Mar-16	Suicide	Toronto East Detention Centre (Provincial)

The chart includes names that are not in the public domain. The Canada Border Services Agency only provides the name of a deceased detainee with the approval of the next-of-kin or if another authority releases the name publicly.

CONTACTS:			
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Issue Fact Sheet #2016-0145
Fiche d'information sur un enjeu #2016-0145

GTA - Death in custody at Toronto East Detention Centre
RGT - Mort en garde à vue au centre de détention de l'Est de Toronto

Issue Fact Sheets are tasked by the Issues Management Secretariat. For tracking purposes, Issue Fact Sheets are named and numbered by the Issues Management Secretariat when they are tasked to the office of primary interest (OPI).

Le Secrétariat de la gestion des questions confie aux bureaux de première responsabilité (BPR) la tâche de produire des fiches d'information sur la question, et fournit un titre et un numéro pour chacune d'entre elles à des fins de suivi.

Office of Primary Interest *Bureau de première responsabilité*	Goran VRAGOVIC, Regional Director General, Greater Toronto Area (GTA) Region
Key Contact *Personne-ressource*	Anna Guida, Acting Director, Enforcement and Intelligence Operations Division (EIOD), GTA Region
Supporting Offices of Collateral Interest *Autres bureaux intéressés offrant un soutien*	Jeanie Chow, Director, Corporate and Program Services Division, GTA Region
Date Issue Began *Date de manifestation de l'enjeu*	*March 7, 2016*
Fact Sheet Creation Date *Date de création de la fiche d'information*	*March 7, 2016*
Date Fact Sheet Updated *Date à laquelle la fiche d'information a été mise à jour*	
Partners Consulted *Partenaires consultés*	Ministry of Community Safety and Correctional Services (MCSCS)
Supporting Documents *Documents de référence*	Case Summary and Analysis attached:

Current Status ***Situation actuelle***	24. CBSA issued a media release at 11:30 am on March 8, 2016.
Next Steps – Management ***Prochaines étapes – mesures à prendre par la direction***	25. GTA Region will follow the established Death in Custody protocol and has commenced its investigation into the incident.
Media Lines ***Infocapsules***	26. We can confirm that a Canada Border Services Agency detainee passed away on March 7, 2016, while under the care and control of the Toronto East Detention Centre. 27. The detainee had been under the care and control of the Ontario Ministry of Community Safety and Correctional Services. In the Greater Toronto Area, the CBSA relies on provincial correctional facilities to detain higher-risk detainees. 28. As a result of the detainee's passing, an investigation has been launched by the various responsible agencies and the CBSA will cooperate fully. 29. The CBSA is committed to ensuring the health and safety of those in our care. As is the case with any death in custody, the CBSA takes this matter seriously and will complete a review of the circumstances surrounding death to identify any factors that could be addressed to prevent any future loss of life.
This information is classified Protected A – Only for distribution internal to CBSA. ***Les renseignements fournis dans le présent document sont classifiés « Protégé A »; par conséquent, ils peuvent uniquement être communiqués à des employés de l'ASFC.***	

Summary of Incident at the Maplehurst Correctional Complex

Background

Greater Toronto Area Region – Immigration Detentions

The Greater Toronto Area Region (GTAR) operates a low-risk detention facility called the Toronto Immigration Holding Centre (TIHC) located in Toronto, Ontario. The TIHC has a capacity to hold 145 individuals with the possibility of expanding to an additional 50 places in the case of an emergency.

Individuals held in the TIHC have been arrested and/or detained under the *Immigration and Refugee Protection Act* (IRPA) for examination, an admissibility hearing or removal.

The TIHC is a low-risk detention facility capable of holding persons who present a flight risk or are unable to establish their identity. The TIHC has facilities capable of safely housing adult males, adult females and family units. Persons who are not suitable for detention in this low-risk facility, including those who have serious mental health issues such that their behaviour cannot be managed, as well as those who pose a danger to themselves or others, are transferred to a provincial detention centre. Provincial correctional facilities are equipped, with the requisite personnel and infrastructure, to manage the detention of persons who present higher risks. These transfers, arranged through a Memorandum of Agreement (MOA) with the province of Ontario, allow the province to assume custodial responsibilities over Canada Border Services Agency (CBSA) detainees. The current MOA was signed on January 21, 2015 by the Minister of Public Safety and Emergency Preparedness, on behalf of Canada, and the Minister of Community Safety and Correctional Services (MCSCS), on behalf of the province of Ontario.

Overview of Criminal Detentions

Criminal Investigators (CI) from the Criminal Investigations Section (CIS) are assigned to cases to investigate whether any criminal charges should be filed against individuals who are in contravene of IRPA. Once an individual is charged, detention may be used to compel attendance at court. In these instances, a bail hearing is conducted so that the Justice of the Peace (JP) can consider the applicability of "Judicial Interim Release" provisions, as required under subsection 515(1) of the Criminal Code of Canada(CCC). This provision of the CCC requires that all persons who have been charged with a criminal offence be ordered released by the JP unless the Prosecutor can show that the continued detention of the individual is justified or that another subsection of 515 of the CCC is applicable. Subsection 515(1) of the CCC places the onus on the Prosecutor to establish that the accused should remain in detention. However, there is an applicable subsection of 515 of the CCC that provides an exception to the release provisions found in subsection (1). Paragraph 515(6)(b) of the CCC, requires that in the case of a person

who is not ordinarily a resident of Canada, such as a Foreign National who has been charged with an indictable offence and has been brought before a JP, that the Foreign National is obligated to show that their continued detention is not justified. When a person who is subject to this provision is unable to demonstrate that their continued detention is not justified, the JP is required to order the continued detention of that person until the legal proceeding is concluded. Subsection 515(6) of the CCC provides for a reverse onus, whereby it is the accused, not the Prosecutor, who must demonstrate whether the continued detention is justified. It also places an obligation on the JP to continue the detention if the reverse onus is not satisfied.

When the JP orders that a person be remanded in custody, it ends their detention under the IRPA, and they are no longer legally or physically in CBSA custody.

Incident Summary

On March 13, 2016, MCSCS officials at MCC contacted the TIHC to advise the CBSA that Mr. Romero had been taken to Milton District Hospital (MDH) with vital signs absent. MCSCS later advised that Mr. Romero had been declared as deceased and Halton Regional Police Services (HRPS) had launched an investigation into the matter. The Coroner's Office (CO) and MCSCS also launched investigations. The CBSA has not yet been advised of the cause of death.

On November 3, 2016, MCSCS announced an inquest into the dealth of Mr. Romero.

Incident at the Maplehurst Correctional Complex and CBSA Management Response

Background

Greater Toronto Area Region – Immigration Detentions

The Greater Toronto Area Region (GTAR) operates a low-risk detention facility called the Toronto Immigration Holding Centre (TIHC) located in Toronto, Ontario. The TIHC has a capacity to hold 145 individuals with the possibility of expanding to an additional 50 places in the case of an emergency.

Individuals held in the TIHC have been arrested and/or detained under the *Immigration and Refugee Protection Act* (IRPA) for examination, an admissibility hearing or removal.

The TIHC is a low-risk detention facility capable of holding persons who present a flight risk or are unable to establish their identity. The TIHC has facilities capable of safely housing adult males, adult females and family units. Persons who are not suitable for detention in this low-risk facility, including those who have serious mental health issues such that their behaviour cannot be managed, as well as those who pose a danger to themselves or others, are transferred to a provincial detention centre. Provincial correctional facilities are equipped, with the requisite personnel and infrastructure, to manage the detention of persons who present higher risks. These transfers, arranged through a Memorandum of Agreement (MOA) with the province of Ontario, allow the province to assume custodial responsibilities over Canada Border Services Agency (CBSA) detainees. The current MOA was signed on January 21, 2015 by the Minister of Public Safety and Emergency Preparedness, on behalf of Canada, and the Minister of Community Safety and Correctional Services (MCSCS), on behalf of the province of Ontario.

Overview of Criminal Detentions

Criminal Investigators (CI) from the Criminal Investigations Section (CIS) are assigned to cases to investigate whether any criminal charges should be filed against individuals who are in contravene of IRPA. Once an individual is charged, detention may be used to compel attendance at court. In these instances, a bail hearing is conducted so that the Justice of the Peace (JP) can consider the applicability of "Judicial Interim Release" provisions, as required under subsection 515(1) of the Criminal Code of Canada(CCC). This provision of the CCC requires that all persons who have been charged with a criminal offence be ordered released by the JP unless the Prosecutor can show that the continued detention of the individual is justified or that another subsection of 515 of the CCC is applicable. Subsection 515(1) of the CCC places the onus on the Prosecutor to establish that the accused should remain in detention. However, there is an applicable subsection of 515 of the CCC that provides an exception to the release provisions found in subsection (1). Paragraph 515(6)(b) of the CCC, requires that in the

case of a person who is not ordinarily a resident of Canada, such as a Foreign National who has been charged with an indictable offence and has been brought before a JP, that the Foreign National is obligated to show that their continued detention is not justified. When a person who is subject to this provision is unable to demonstrate that their continued detention is not justified, the JP is required to order the continued detention of that person until the legal proceeding is concluded. Subsection 515(6) of the CCC provides for a reverse onus, whereby it is the accused, not the Prosecutor, who must demonstrate whether the continued detention is justified. It also places an obligation on the JP to continue the detention if the reverse onus is not satisfied.

When the JP orders that a person be remanded in custody, it ends their detention under the IRPA, and they are no longer legally or physically in CBSA custody.

Incident Summary

On March 13, 2016, MCSCS officials at MCC contacted the TIHC to advise the CBSA that Mr. Romero had been taken to Milton District Hospital (MDH) with vital signs absent. MCSCS later advised that Mr. Romero had been declared as deceased and Halton Regional Police Services (HRPS) had launched an investigation into the matter. The Coroner's Office (CO) and MCSCS also launched investigations. The CBSA has not yet been advised of the cause of death.

On November 3, 2016, MCSCS announced an inquest into the dealth of Mr. Romero.

CBSA Management Response and Recommendations

The Agency's standard operating procedures following a death in custody is to review the incident in the context of our framework of legislation, policies and practices, in order to identify any gaps and make recommendations where improvements can be made. Recommendations may include references to legislation, policies and practices which do not necessarily bear directly on the death in custody.

Care and Control

Issue:

Recommendation: POD will assess whether the current port practice of requesting support from additional BSOs to help maintain care and control is adequate to meet the needs of the operation. If it is determined that the practice is adequate, then steps should be taken to ensure this message is periodically reinforced amongst staff.

Management Response:

Management will reestablish its expectations that all Border Services Officers will be diligent in ensuring that travellers are properly secured within the CBSA office and will take necessary steps to prevent travellers from leaving the CBSA area without authorization.

Communication of Pertinent Information

Issue:

Recommendation: Enforcement staff at all locations within the GTAR will be reminded to ensure that they are aware of all of the pertinent information held on enforcement files prior to taking action. Enforcement staff will also be reminded to ensure that this information is communicated to stakeholders where applicable.

Management Response:

Regional Program Services will ensure that clear instructions are provided to regional staff with respect to the collection, maintenance, review and communication of pertinent client information prior to taking action internally or with stakeholders.

Detainee Medical Form (DMF)

Issue: The TIHC intake process requires that the contracted guard complete a new DMF.

Recommendation: Instructions will be issued to TIHC staff to ensure that they accurately complete the DMF and also review all information at their disposal related to the detainee's medical and risk assessment. Information from the TIHC detainee file will be transferred to the holder of the permanent Immigration file to ensure that the file holds all relevant information related to the detainee.

Management Response:

EIOD Management will review protocols related to obtaining and sharing of detainee medical information with Enforcement and Intelligence Programs and MCSCS to ensure improved identification and communication of medical issues.

Detention Review Notes

Issue:

Recommendation: Procedures will be implemented whereby notes from detention reviews of cases that are still undergoing an examination will be delivered to the holder of the Immigration file. Furthermore, any relevant information that comes to light during the detention review will be independently communicated to the Hearings Manager for furtherance to the Immigration file holder for their consideration.

Management Response:

Hearings Officers and Managers will be advised to liaise directly with the holders of Immigration case files when new and pertinent information, which the holder of the case file was previously unaware of, is made available during the detention review process.

Obtaining Information Prior to Making a MDR Decision

Issue: The standard practice of obtaining mitigating information prior to making a Ministers Delegate Review (MDR) decision are sometimes not followed when the MDR is conducted at remote locations without access to the CBSA network.

Recommendation: Enforcement staff in the GTAR will be reminded that persons undergoing an MDR should have an opportunity to provide submissions to the decision maker prior to the decision being made. For instance, where a MDR will be conducted in a remote location enforcement staff will be provided with alternate options such that every reasonable effort will be made to allow for submissions to be received in a manner similar to those where the MDR will be conducted in a facility with access to the CBSA network.

Management Response:

GTAR will review the practices that occur when Minister's Delegate Reviews are to be conducted at remote locations outside of CBSA offices. This review will confirm that the person who is the subject of an Immigration enforcement action is aware of the allegations made against them and is afforded the opportunity to address those allegations with the officer conducting the MDR, prior to that officer making a final decision on the case. This is in keeping with the principles of natural justice and procedural fairness.

Communication Protocols

Exchange of Medical Information

Issue: The current MOA with MCSCS should contain provisions for the exchange of medical information between the CBSA and provincial facilities as it pertains to Immigration detainees.

Recommendation: It remains unclear what exact medical information was shared between the TIHC and the MCC (in particular, medical history and medication prescribed). This exchange could occur between medical professionals of each organization.

Management Response:

Medical staff are now stationed at the TIHC 24 hours a day 7 days a week. Instances of concern are discussed between the Medical Officers of the respective institutions.

Request for Funding

Issue:

Recommendation: The GTAR will make it a standard practice to immediately notify the office of the Vice President of the Operations Branch that a request for funding has been received to cover costs associated with the funeral.

Management Response:

Corporate and Program Services Division (CPSD) will create a shared folder where the Death in Custody protocols will be housed for the GTAR. Included in these protocols will be instructions to notify the Vice President of Operations Branch that a request has been received to cover the costs associated with the funeral of someone who has passed away while in CBSA custody.

Conclusion

The CBSA has worked to ensure that all recommendations were implemented swiftly to strengthen the detentions program and to better support the health, welfare and safety of detainees.

Updated: 2017-01-19

MANAGEMENT RESPONSE AND ACTION PLAN FOR THE INCIDENT AT MAPLEHURST CORRECTION COMPLEX

As a result of the incident at the Maplehurst Correctional Complex on March 13, 2016, the Greater Toronto Area Region initiated an internal review of its operations to assist in identifying procedural improvements to strengthen the detention program in the Greater Toronto Area Region.

RECOMMENDATION 1

POD will assess whether the current port practice of requesting support from additional BSOs to help maintain care and control is adequate to meet the needs of the operation. If it is determined that the practice is adequate, then steps should be taken to ensure this message is periodically reinforced amongst staff.

Management Response
Management will reestablish its expectations that all Border Services Officers will be diligent in ensuring that travellers are properly secured within the CBSA office and will take necessary steps to prevent travellers from leaving the CBSA area without authorization.

Management Action Plan	**Status**	**Completion Date**
1.1 The POD Director sent an email to all staff setting expectations for properly securing travellers who are in the CBSA area. 1.2 POD Management will ensure key secondary areas are regularly monitored using Closed Circuit Television and CBSA personnel. 1.3 POD Management will periodically reinforce the need to ensure travellers are properly secured through established Port of Entry communication protocols.	Completed	January 12, 2017

RECOMMENDATION 2

Enforcement staff at all locations within the GTAR will be reminded to ensure that they are aware of all of the pertinent information held on enforcement files prior to taking action. Enforcement staff will also be reminded to ensure that this information is communicated to stakeholders where applicable.

Management Response
Regional Program Services will ensure that clear instructions are provided to regional staff with respect to the collection, maintenance, review and communication of pertinent client information prior to taking action internally or with stakeholders.

Management Action Plan	**Status**	**Completion Date**
2.1 Program Services will send a message to all regional enforcement staff as a reminder to conduct a complete review of available information to ensure pertinent factors are taken into consideration during the decision making process.	In-progress	January 31, 2017

RECOMMENDATION 3

Instructions will be issued to TIHC staff to ensure that they accurately complete the DMF and also review all information at their disposal related to the detainee's medical and risk assessment.

Information from the TIHC detainee file will be transferred to the holder of the permanent Immigration file to ensure that the file holds all relevant information related to the detainee.

Management Response
EIOD Management will review protocols related to obtaining and sharing of detainee medical information with Enforcement and Intelligence Programs and MCSCS to ensure improved identification and communication of medical issues.

Management Action Plan	**Status**	**Completion Date**
3.1 Enforcement and Intelligence Operations Division (EIOD) has conducted an internal review and instituted a new governance structure related to the completion of the NRAD and DMF documents providing improved oversight. The contract guards at the TIHC no longer complete the DMF during the in-take process. The DMF will continue to be completed by the detaining CBSA officer.	Completed	TBC
3.2 Medical staff is now stationed at the TIHC 24 hours a day 7 days a week. Detainees and their corresponding DMF are evaluated by the medical staff.	Completed	June 2016
3.3 The TIHC Medical Officer has provided an assessment confirming that the disclosure of medical information without consent is warranted when it is necessary to reduce the risk of serious bodily harm to a person or group of persons. Instances of concern are discussed between the Medical Officers of the respective institutions.	In-progress	March 31, 2017

RECOMMENDATION 4

Procedures will be implemented whereby notes from detention reviews of cases that are still undergoing an examination will be delivered to the holder of the Immigration file. Furthermore, any relevant information that comes to light during the detention review will be independently communicated to the Hearings Manager for furtherance to the Immigration file holder for their consideration.

Management Response
Hearings Officers and Managers will be advised to liaise directly with the holders of Immigration case files when new and pertinent information, which the holder of the case file was previously unaware of, is made available during the detention review process.

Management Action Plan	**Status**	**Completion Date**
4.1 POD will provide contact information for the Superintendents managing the Immigration areas at Toronto Pearson International Airport (TPIA) to EIOD Management so that Hearings staff are able to have direct contact with the Immigration case file holders when relevant instances arise during the detention review process.	Completed	January 11, 2017
4.2 EIOD Management will provide direction to Hearings staff regarding the communication of pertinent issues to the Immigration case file holders and will provide current contact information for the Superintendents at POD.	In-progress	January 16, 2017
4.3 POD and EIOD Management will work on standard operating procedures to outline how new information obtained during a Hearings or a Port of Entry examination process will be recorded in CBSA databases.	In-progress	January 16, 2017

RECOMMENDATION 5

Enforcement staff in GTAR will be reminded that persons undergoing an MDR should have an opportunity to provide submissions to the decision maker prior to the decision being made. For instance, where MDR will be conducted in a remote location enforcement staff will be provided with alternate options such that every reasonable effort will be made to allow for submissions to be received in a manner similar to those where the MDR will be conducted in a facility with access to the CBSA network.

Management Response
GTAR will review the practices that occur when Minister's Delegate Reviews are to be conducted at remote locations outside of CBSA offices. This review will confirm that the person who is the subject of an Immigration enforcement action is aware of the allegations made against them and is afforded the opportunity to address those allegations with the officer conducting the MDR, prior to that officer making a final decision on the case. This is in keeping with the principles of natural justice and procedural fairness.

Management Action Plan	**Status**	**Completion Date**
5.1 EIOD has conducted a review of its MDR processes and has confirmed that its current practices are in keeping with the principles of natural justice and procedural fairness.	Completed	January 16, 2017
5.2 POD has conducted a review of its MDR processes and has reminded staff to ensure that persons are advised of the allegations being made against them and to provide the person with an opportunity to address those allegations with the decision maker prior to a final decision being made. To facilitate this staff at POD have been advised to complete the required paperwork manually at remote locations after conducting the MDR.	Completed	January 13, 2017

RECOMMENDATION 7

It remains unclear what exact medical information was shared between the TIHC and the MCC (in particular, medical history and medication prescribed). This exchange could occur between medical professionals of each organization.

Management Response
Medical staff are now stationed at the TIHC 24 hours a day 7 days a week. Instances of concern are discussed between the Medical Officers of the respective institutions.

Management Action Plan	**Status**	**Completion Date**
EIOD Management will confirm with the respective Medical Officers whether appropriate communication protocols are in place and to being adhered to, allowing for the transfer of relevant medical information between organizations.	In-progress	February 1, 2017

RECOMMENDATION 8

The GTAR will make it a standard practice to immediately notify the office of the Vice President of the Operations Branch that a request for funding has been received to cover costs associated with the funeral.

Management Response
Corporate and Program Services Division (CPSD) will create a shared folder where the Death in Custody protocols will be housed for the GTAR. Included in these protocols will be instructions to notify the Vice President of Operations Branch that a request has been received to cover the costs associated with the funeral of someone who has passed away while in CBSA custody.

Management Action Plan	**Status**	**Completion Date**
8.1 Program Services has implemented internal protocols such that, upon being notified that the CBSA has received a request to pay for the funeral of a person who has died while in the custody of the CBSA, Program Services will advise the Regional Director General, or their delegate of this request along with the need to notify the Vice President of Operations Branch. Program Services will draft a briefing note for submission to the Vice President of Operations requesting the approval of an ex-gratia payment to cover the expenses related to the funeral.	Completed	May 2016

Issue Fact Sheet #2016-0146
Fiche d'information sur un enjeu #2016-0146

GTA - Death in custody at Maplehurst Correctional Complex
RGT - Mort en garde à vue au Complexe Correctionnel de Maplehurst

Issue Fact Sheets are tasked by the Issues Management Secretariat. For tracking purposes, Issue Fact Sheets are named and numbered by the Issues Management Secretariat when they are tasked to the office of primary interest (OPI).

Le Secrétariat de la gestion des questions confie aux bureaux de première responsabilité (BPR) la tâche de produire des fiches d'information sur la question, et fournit un titre et un numéro pour chacune d'entre elles à des fins de suivi.

Office of Primary Interest ***Bureau de première responsabilité***	Goran VRAGOVIC, Regional Director General Greater Toronto Area (GTA) Region
Key Contact ***Personne-ressource***	Anna Guida, Acting Director Enforcement and Intelligence Operations Division (EIOD), GTA Region
Supporting Offices of Collateral Interest ***Autres bureaux intéressés offrant un soutien***	Marija CUVALO, Assistant Director Removals Unit, EIOD, GTA Region Jonathan KAMIN, Assistant Director Detentions and Operational Support, EIOD, GTA Region Jeanie CHOW, Director Corporate and Program Services Division, GTA Region
Date Issue Began ***Date de manifestation de l'enjeu***	*March 13, 2016*
Fact Sheet Creation Date ***Date de création de la fiche d'information***	*March 13, 2016*
Date Fact Sheet Updated ***Date à laquelle la fiche d'information a été mise à jour***	
Partners Consulted ***Partenaires consultés***	Ministry of Community Safety and Correctional Services (MCSCS)
Supporting Documents	Case Summary and Analysis attached:

Documents de référence	 CBSA Summary history for ROMERO ,
Key Facts ***Faits principaux***	**Summary:** 1. Mr. Francisco Javier ROMERO ASTORGA [Universal Client Identification (UCI) 2. 3. 4. 5. 6. On March 13, 2016, the CBSA was advised by the MCSCS that Mr. ROMERO ASTORGA had died at 09h04. **Sequence of Events (times are approximate):** 7. 8.

	18. On March 13, 2016 at approximately 09h05, a G4S supervisor, providing guard services under contract at the Toronto Immigration Holding Centre, advised the CBSA that Mr. ROMERO ASTORGA has been taken to Milton District Hospital with vital signs absent. 19. On March 13, at 09h15, the G4S supervisor advised the CBSA that MCC staff had called to report that Mr. ROMERO ASTORGA had been declared dead at 09h04 and that the Halton Regional Police Services would take over the investigation. 20. 21. 22. 23. 24. 25. 26.
Considerations or Implications ***Considérations ou répercussions***	27. This is the second death-in-custody in a provincial correctional facility in the last 7 days. There may be questions on what safeguards are in place to protect the health and safety of detainees. 28. Questions may be raised as to whether individuals charged with and charges under *IRPA* should be detained in a provincial correction facility, where typically higher-risk inmates are held.

	29. 30. Recent negative media coverage on how the CBSA has handled persons with mental health issues while in detention could resurface and renew arguments that an independent oversight body is required.
Current Status ***Situation actuelle***	
Next Steps – Management ***Prochaines étapes – mesures à prendre par la direction***	31. GTA Region will follow the established Death-in-Custody protocol and has commenced its fact-finding into the incident.
Media Lines ***Infocapsules***	32. We can confirm that a Canada Border Services Agency (CBSA) detainee passed away on March 13, 2016, while under the care and control of the Maplehurst Correctional Complex. 33. In the Greater Toronto Area, the CBSA relies on provincial correctional facilities to detain higher-risk detainees. 34. As a result of the detainee's passing, an investigation is underway by the various responsible agencies and the CBSA will cooperate fully. 35. The CBSA is committed to ensuring the health and safety of those in our care. As is the case with any death in custody, the CBSA takes this matter seriously and will complete a review of the circumstances surrounding death.
This information is classified Protected A – Only for distribution internal to CBSA. ***Les renseignements fournis dans le présent document sont classifiés « Protégé A »; par conséquent, ils peuvent uniquement être communiqués à des employés de l'ASFC.***	

Management Response and Action Plan for the In-Custody Death of

OVERALL MANAGEMENT RESPONSE

As a result of the in-custody death of October 30, 2017, the Greater Toronto Area Region initiated an internal review of operations in an effort to strengthen the Agency's detention program.

As per the Due Diligence Report, management has identified four recommendations that should be implemented in the Greater Toronto Area and Southern Ontario Regions:

- Review of All Arrest Files and Standardize Forms;
- Engage the MCSCS on A59, A142 and A143;
- File Documentation and Managing Use of Detention; and,
- Clarify and Review Communication Protocols with Ontario.

RECOMMENDATION 1: Review of All Arrest Files and Improve File Documentation

1.1 It is recommended that all regions sending detainees to the IHC ensure managerial review and oversight of all arrest files resulting in detention, prior to the file being sent for scheduling of a 48-hour detention review.

The review of the arrest file should confirm that detention is warranted and the location of detention matches risk factors. Management should ensure that forms have been completed properly and that IEOs are documenting their activities. This includes periodic reviews of officer notebooks.

1.2 It is recommended that a nationally-consistent checklist be implemented in all regions. The checklist should be in compliance with national policy and procedures.

A local checklist has been created to assist managers for this purpose in the GTA Region. The checklist covers all requirements for arrest files, including but not limited to, email notifications that need to be sent, the *Notice of Arrest* to be uploaded into GCMS, the completion of the Vienna Convention form, DMF, NRAD, and the various electronic work to be completed. This best practice will be shared with the HQ Programs.

1.3 It is recommended that the GTA Region's *Notice of Arrest SOPs* be shared with all regions for consideration of similar implementation. It will be shared via NHQ EIPD as a best practice. The SOPs provide guidance on what should be considered prior, during, and after an arrest. They also address how the decision regarding release or detention should be articulated in a *Notice of Arrest*.

1.4 It is recommended that more training on NRADs be provided and completed, as well as emphasizing the importance of note-taking and documenting decisions. This should not only be for officers, but also for supervisors, managers, and peer reviewers. The implementation of the new NRAD in January 2018 is expected to replace regionally-based admissions criteria, and provide greater national consistency.

1.5 It is recommended that there be greater oversight of placement decisions should an individual be placed outside of an IHC. It is presumed that in-line with the new NRAD, individuals will be detained at an IHC, where one is available.

1.6 It is recommended that all regions review the current physical file jackets that are being used, and to determine if a more secure alternative is available to safeguard physical documents during transport. Additionally, it is recommended that all regions review their current screening sheet for incoming files, and incorporate a check of required documents when a detained arrest file is being transferred into the office.

1.7 It is recommended that forms and important documents, such as the NRAD and DMF, are scanned and uploaded to national electronic databases, like GCMS, upon the officer's return to the office. This would make the forms available in real time, and readily available should the physical file not be in hand because it is being transported from another region, or office.

Management Response
Regional management is in agreement with the above recommendations.

	Management Action Plan	Status	Completion Date
1.1	a) Implement National policy on detention oversight and governance to ensure all detention decisions that lead to admittance to a detention facility are reviewed by a management representative. b) GTA to develop region specific procedures to align with National policy and directives related to detention oversight and decision making (i.e. email directive of 2017-12-21 and 2017-12-14). *Note: As per the new NRAD, all cases destined for the IHC are reviewed by the IHC manager or delegate (A56), but this has been an issue for those cases destined for the jails, as no one has been tasked with reviewing these cases. Cases originating in other regions (SOR, NOR) should in all cases be discussed with a supervisor/manager in the GTA (receiving region)*		Completed December 21, 2017
1.2	a) GTA to update the local checklist to assist managers in conducting reviews of arrest files with input from all regions transferring detainees to the GTA IHC. *Note: This process needs to be integrated with POE procedures (including PIA).*		
	b) National Headquarters (EIPD) to review current tools and forms used by all regions during the arrest and detention process to determine if procedures require amendment/refinement	Aligns with National Action Plan Deliverable	April 13, 2018

1.3	Refer to 1.2 above. EIPD will facilitate adoption of standard processes for reviewing arrests and documenting decisions based upon GTA best practices via feedback from all regions. *Note: VP Operations has stated there is a need for EIPD to review to ensure that all regions are implementing and following changes made to the Notice of Arrest SOPs and forms. This will be accomplished by scheduling a national teleconference 6 months after the new procedures and forms are implemented.*		
1.4	a) Training on the use of the NRAD and DMF to be provided to CBSA officers (GTA) and managers who exercise arrest and detention authorities under the IRPA. *Note: Training should include keeping a record of completion.* b) GTA to implement a transition strategy to cover the period between the new IHC admissions guidelines taking effect and completion of construction of new infrastructure at the site.		
1.5	GTA IHC management to engage with SOR and NOR management on risk management options for complex cases and develop an admissions process.	Aligns with National Action Plan Deliverable	Feb 16, 2018
1.6	GTA to assign a supervisor or manager to conduct a comparison of pricing and feature options for current file jackets with what is available to replace existing products.	Aligns with National Action Plan Deliverable	August 1, 2018
1.7	a) As per NHQ EIOD direction, GTA to review all active detention cases to ensure alignment to national directives and policy related to the storing and capture of data in NCMS and GCMS (ie: NRAD and DMF uploaded to GCMS). b) NHQ (EIPD/EIOD), in consultation with regions, to identify and create plan for IT system enhancements based on identified needs, to better support detention case management. (ie: capturing of information in GCMS to facilitate storing, capture and retrieval of data by staff). *Note: All NRAD and DMF should be scanned and downloaded to GCMS PRIOR to transfer. NCMS must also be updated.*		

RECOMMENDATION 2: Engage the MCSCS on A59, A142 and A143

2.1 It is recommended that the CBSA engage the MCSCS in a discussion on when and how individuals will be delivered into CBSA custody at the expiration of their terms of imprisonment. This may result in a renegotiation of the Memorandum of Understanding.

While alternatives to detention always need to be considered prior to the commencement of immigration detention, there are times when the specific risks associated with an individual may justify them remaining physically incarcerated at a provincial detention centre while custody transfers from the criminal court system to the CBSA.

Section 59 of the *IRPA* provides legislative authority for the transfer of an inmate at the end of their criminal sentence into CBSA custody. Thus, the institution shall deliver the inmate to an IEO at which point the CBSA warrant is executed and the person may enter immigration detention. The detainee must then be brought before the Immigration Division for a review of their detention within 48 hours.

Section 59 of the *IRPA* imposes an obligation on correctional institutions to cooperate with the CBSA to facilitate the transfer, but does not impose a strict obligation to detain an inmate for an unreasonable period of time (i.e. more than one day).

There is a mechanism in the *IRPA* that exists to ensure a person's detention is valid and authorized at all times which should be discussed with Ontario:

> ***Duties of peace officers to execute orders***
> ***142*** *Every peace officer and every person in immediate charge or control of an immigrant station shall, when so directed by an officer, execute any warrant or written order issued under this Act for the arrest, detention or removal from Canada of any permanent resident or foreign national.*
>
> ***Authority to execute warrants and orders***
> ***143*** *A warrant issued or an order to detain made under this Act is, notwithstanding any other law, sufficient authority to the person to whom it is addressed or who may receive and execute it to arrest and detain the person with respect to whom the warrant or order was issued or made.*

2.2 It is recommended to leave immigration warrants unexecuted while a person is on court hold or serving their sentence, but to still provide the detention facility with an A59 Order of the CBSA to Deliver Inmate. As a backup, all institutions should query clients in CPIC prior to release, and therefore should advise the CBSA of the outstanding warrant at that time.

2.3 It is recommended that the CBSA seek an arrangement whereby the MCSCS will execute an outstanding warrant on the CBSA's behalf at the end of an individual's sentence. Clarity will need to be provided to the MCSCS and detention facility regarding the CBSA point of contact, and whether the client can be transported by contracted IHC guards as part of the delivery process referenced in section 59.

Challenges for the CBSA will include ensuring that an NRAD is completed where there is a reasonable expectation that transfer to CBSA custody is imminent, and that the client receives a 48-hour detention review after the warrant is executed.

Management Response

Regional management is in agreement with the recommendation that the CBSA make better use of A59 Orders for Detention. The A59 order was introduced into legislation early in IRPA, but most regions remained status quo with their arrest processes.

There is no legal authority for a person to fall under two different custody regimes simultaneously, yet current operating practices do not reflect this. The CBSA has lost legal challenges in recent years, as a result. In one case, the CBSA was ordered to pay $6,000/day for each day that the client did not get a detention review while he was on both court hold and immigration hold.

A59 is not a hold or detention order, but it mandates an institution to contact CBSA once the subject has come off court hold:

> *Immigration and Refugee Protection Act (S.C. 2001, c. 27)*
> *Incarcerated foreign nationals*
> *59 If a warrant for arrest and detention under this Act is issued with respect to a permanent resident or a foreign national who is detained under another Act of Parliament in an institution, the person in charge of the institution shall deliver the inmate to an officer at the end of the inmate's period of detention in the institution.*

An A59 order, in conjunction with a warrant for arrest, should be used by both the POE and EIOD-Inland anytime a client is detained under any other act of Parliament (usually the *Criminal Code* of *Canada* or the *Controlled Drugs and Substances Act*) in lieu of a detention order. This will provide authority for the jail to detain the client until they can be delivered to the CBSA.

At that point, the CBSA will action the warrant, complete the NRAD, DMF, etc., and detain for immigration purposes. Who conducts the transports (MCSCS, IEOs, or G4S) needs to be worked out with MCSCS.

The NRAD should not be completed until a person is on CBSA hold, otherwise the CBSA is committing to monitor their detention every 60 days despite the fact that we have no authority to change their detention location/status at that time.

The CBSA warrants attached to the A59 should be put on CPIC if the duration of time in custody is unknown or likely to be lengthy. All institutions are supposed to run a CPIC check before release and therefore should advise the CBSA of the outstanding warrant at that time.

Management Action Plan	Status	Completion Date
2.1 NHQ EIPD and GTA to engage the Ontario Ministry of Community Safety and Correctional Services, (MCSCS) in a discussion on when and how warrants will be executed, detention orders issued, and how individuals will be transferred into CBSA custody at the expiration of their terms of imprisonment.		September 30, 2018
2.2 a) NHQ EIPD to undertake a review of Section 59 of the IRPA, which provides measures for the transfer of custody of a foreign national who is at the end of serving a criminal sentence, to identify gaps in current policy direction. EIPD to update respective policy directives (i.e. ENF manuals) as appropriate.		August 1, 2018
b) NHQ EIPD and GTA to review existing Detention MOU with Ontario to determine if changes are required to clarify mechanisms to transfer of custody of an individual from criminal hold to immigration hold.		September 1, 2018
2.3 GTA to develop business processes and procedures in accordance within National directive on the transfer of custody of an individual as per 2.2 (b) above.	Completion date will be after September 1, 2018	

RECOMMENDATION 3: File Documentation and Managing Use of Detention

3.1 It is recommended that the regions obtain national clarification on the *A44 Narrative Report* forms and processes. There are currently multiple variations of the *A44 Narrative Report* form that are used, and the processes differ slightly between regions; but the same elements as listed in the ENF 6 manual, are used.

3.2 It is recommended that the regions obtain national clarification on the adoption of best practices, such as: adopting the use of a warrant checklist; inputting other known information on the *A44 Narrative Report;* and, when information is not available or not received to document that in the forms. These practices will strengthen overall file documentation.

3.3 It is recommended that the CBSA take a balanced approach in responding to questions around the decision to detain. An officer must consider the factors listed in the *Immigration and Refugee Protection Regulations*, sections 246 to 248, as well as reasonable alternatives to detention and document the detention decision in detail. The CBSA should take steps to ensure that decision rationale for enforcement actions are adequately documented on file.

Management Response
Regional management is in agreement with the above recommendations.

Management Action Plan	**Status**	**Completion Date**
3.1 NHQ EIOD to compile an inventory of all current practices across the country in relation to the processes and forms used to report and document inadmissibility under the IRPA (A44). A report identifying the uses, variation and gaps in forms and documentation shall be created.		To be completed by September 30, 2018
3.2 GTA to request NHQ EIPD undertake review of gap analysis and regional practices to ensure ENF manuals reflect consistent policy approach and direction.		To be completed before April 30, 2018
3.3 GTA to implement regional processes aligned with National direction on detention oversight and governance, and ensure that regular file reviews are undertaken to ensure completeness of officer notes and notes to file.		To be completed before April 30, 2018

RECOMMENDATION 4: Clarify and Review Communication Protocols with Ontario

4.1 It is recommended that the regions seek a national umbrella policy under which specific agreements can be negotiated with provincial authorities, such as the MCSCS in Ontario.

4.2 It is recommended that the CBSA perform regular outreach sessions with the MCSCS to review existing protocols for effectiveness and accuracy. The CBSA should seek to develop interactions too address lack of familiarity with each other's processes, and to create a stronger mechanism for resolving issues that may be identified. Care should also be taken that the proper response options are in place should the CBSA receive notification of an issue concerning a client.

4.3 It is recommended that it be made standard practice for G4S guards to bring a release order when attending a hospital to transfer custody of a detainee from corrections staff to CBSA/G4S.

Management Response
Regional management is in agreement with the above recommendations.

Management Action Plan	**Status**	**Completion Date**
4.1 Refer to 2.1 above.		
4.2 GTA regional management to establish a recurring annual engagement schedule (i.e. quarterly) of outreach sessions with the MCSCS management to discuss operational issues. *Note: IHC management is generally not focussed on jail detainees. Consideration should be given if additional EIOD Managers are best involved in these meetings.*		To be completed prior to April 1, 2018
4.3 IHC management to make arrangements and notify duty managers of any changes to procedures required with regard to G4S attending hospitals. *Note: It is anticipated that POD will also have their own contract with G4S and transport to the hospital – separate and apart from the IHC contract. Coordination is required.* *Note: Along the same line as A59 is the issue of CBSA jurisdiction when a Form 1 is executed (Application by Physician for Psychiatric Assessment). Clarification is required as to whether this is a detention order, whether the client is still considered to be on CBSA hold for this period (maximum of 72 hours), and what obligation there is for hospital officials to apprise CBSA upon the client being discharged.*		To be completed prior to April 1, 2018

Incident at the Toronto East Detention Centre and CBSA Management Response

Background

Greater Toronto Area Region – Immigration Detentions

The Greater Toronto Area Region (GTAR) operates a low-risk detention facility called the Toronto Immigration Holding Centre (TIHC) located in Toronto, Ontario. The TIHC has a capacity to hold 145 individuals with the possibility of expanding to an additional 50 places in the case of an emergency.

Individuals held in the TIHC have been arrested and/or detained under the *Immigration and Refugee Protection Act* (IRPA) for examination, an admissibility hearing or removal.

The TIHC is a low-risk detention facility capable of holding persons who present a flight risk or are unable to establish their identity. The TIHC has facilities capable of safely housing adult males, adult females and family units. Persons who are not suitable for detention in this low-risk facility, including those who have serious mental health issues such that their behaviour cannot be managed, as well as those who pose a danger to themselves or others, are transferred to a provincial detention centre. Provincial correctional facilities are equipped, with the requisite personnel and infrastructure, to manage the detention of persons who present higher risks. These transfers, arranged through a Memorandum of Agreement (MOA) with the province of Ontario, allow the province to assume custodial responsibilities over Canada Border Services Agency (CBSA) detainees. The current MOA was signed on January 21, 2015 by the Minister of Public Safety and Emergency Preparedness, on behalf of Canada, and the Minister of Community Safety and Correctional Services (MCSCS), on behalf of the province of Ontario.

Overview of CBSA Detention Responsibilities

The CBSA contracts a private security company to provide guard and transportation services related to the daily operation of the TIHC. These guard and transportation services include, but are not limited to:

- the care and control* of persons detained under the IRPA at the TIHC;
- the care and control of persons detained under the IRPA while receiving care at medical facilities; and
- the management and provision of the safe and secure transportation of detainees to and from the TIHC, CBSA offices (including ports of entry), provincial detention centres and/or hospital facilities.

**medical services are provided by independent healthcare contractors. However, serious medical and mental health issues are referred to hospitals.*

CBSA staff are present at the facility and are responsible for management oversight related to the provision of these detention services. The CBSA is also responsible for ensuring CBSA related legislation and policies are properly applied as it relates to detainees.

Incident Summary

On March 7, 2016, the CBSA was contacted by the TEDC Medical Manager and advised that TEDC confirmed that

TEDC staff performed First Aid on until Emergency Medical Services could attend. The CBSA was advised that was deceased. CBSA was also advised that the Toronto Police Service (TPS), Coroner's Office (CO) and MCSCS had each launched investigations into the matter.

CBSA Management Response and Recommendations

The Agency's standard operating procedures following a death in custody is to review the incident in the context of our framework of legislation, policies and practices, in order to identify any gaps and make recommendations where improvements can be made. Recommendations may include references to legislation, policies and practices which do not necessarily bear directly on the death in custody.

NRAD and NRRD Documents

Issue: Inconsistencies were identified with the completion of the NRAD and NRRD documents. These documents were not completed with the required frequency. Furthermore, in some cases, the documented responses were incomplete.

Recommendation: The GTAR will develop improved governance, monitoring and management oversight of NRAD and NRRD document completion.

Management Response:

Management will develop a number of processes and procedures aimed at ensuring that the NRAD is completed accurately and on a timely basis.

Interpreter for Medical Assessments

Issue: The CBSA was informed that the detainee was examined by the province's medical staff prior to his transfer from one facility to the next (from CECC to TEDC and again from TEDC in preparation for the detainee's removal from Canada) without the use of an interpreter. This could have impacted the province's ability to conduct an accurate medical assessment.

Recommendation: The GTAR will request that the MCSCS provide interpreter services when conducting medical assessment of immigration detainees. In those instances where this is not possible, the MCSCS will notify the GTAR that they were unable to conduct a proper medical assessment. The GTAR will make arrangements for interpreter services to be made available for use by MCSCS medical staff or will defer the removal until such time that interpreter services can be made available.

Management Response:

There are two issues: Interpreter services being provided for CBSA detainees when conducting medical assessments, and that interpreter services are provided in a similar fashion for fit to fly assessments. EIOD Management will work with MCSCS and Programs Branch to implement appropriate risk mitigation strategies.

Request for Funding

Issue:

Recommendation: The GTAR will make it a standard practice to immediately notify the office of the Vice President of the Operations Branch that a request for funding has been received to cover costs associated with the funeral.

Management Response:

Corporate and Program Services Division (CPSD) will create a shared folder where the Death in Custody protocols will be housed for the GTAR. Included in these protocols will be instructions to notify the Vice President of Operations Branch that a request has been received to cover the costs associated with the funeral of someone who has passed away while in CBSA custody.

Conclusion

The CBSA has worked to ensure that all recommendations were implemented swiftly to strengthen the detentions program and to better support the health, welfare and safety of detainees.

Updated: 2017-01-19

Issue Fact Sheet

Prairie Region - Death in custody at Edmonton Remand Centre

Issue Fact Sheets are tasked by the Issues Management Secretariat. For tracking purposes, Issue Fact Sheets are named and numbered by the Issues Management Secretariat when they are tasked to the office of primary interest (OPI).

Le Secrétariat de la gestion des questions confie aux bureaux de première responsabilité (BPR) la tâche de produire des fiches d'information sur la question, et fournit un titre et un numéro pour chacune d'entre elles à des fins de suivi.

Office of Primary Interest ***Bureau de première responsabilité***	Kim Scoville, Regional Director General Prairie Region
Key Contact ***Personne-ressource***	Warren Duncan, Acting Manager Edmonton Inland Enforcement, Enforcement and Intelligence Operations Division (EIOD), Prairie Region
Supporting Offices of Collateral Interest ***Autres bureaux intéressés offrant un soutien***	Mike SKAPPAK, Director Enforcement & Intelligence Operations Division (EIOD), Prairie Region Bill AXTEN, Assistant Director Enforcement & Intelligence Operations Division (EIOD), Prairie Region Brent PATTEN, Director Corporate and Program Services Division (CPSD), Prairie Region
Date Issue Began ***Date de manifestation de l'enjeu***	*May 14, 2016*
Fact Sheet Creation Date ***Date de création de la fiche d'information***	*May 15, 2016*
Date Fact Sheet Updated ***Date à laquelle la fiche d'information a été mise à jour***	*May 15, 2016*
Partners Consulted ***Partenaires consultés***	Edmonton Remand Centre Office of the Chief Medical Examiner of Alberta
Supporting Documents ***Documents de référence***	Case Summary and Analysis attached:

	16-05-15 - Case History - KHOR.doc
Key Facts ***Faits principaux***	**Summary:** 1. 2. 3. 4. 5. 6. On the morning of May 15, 2016 at approximately 09:30 hrs, a CBSA Inland Enforcement officer in Edmonton received a telephone call from the admitting support staff at Edmonton Remand Centre, indicating that at approximately 22:30 hrs (MST) on May 14, 2016, Mr. KHOR was found non-responsive in his cell and had been pronounced dead. 7. 8. **Sequence of Events (times are approximate):** 9.

	10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 15 May 2016 The Edmonton Remand Centre advised the CBSA that he died on14 May 2016 at approximately 22h30. The Coroner is aware.
Considerations or Implications	28. There may be questions on what safeguards are in place to protect the health and safety of detainees. Questions could also arise as to why the CBSA sought a

Considérations ou répercussions	judicial review of the IRB's decision to release Mr. KHOR from detention in April, 2016. 29. Potential for negative media coverage due to a death while in CBSA custody. Prairie Regional Communications is monitoring for any resultant media coverage of this matter. 30. Recent negative media coverage on how the CBSA has handled persons with mental health issues while in detention could resurface and renew arguments that an independent oversight body is required.
Current Status ***Situation actuelle***	31. Edmonton Inland Enforcement has followed up with the Edmonton Remand Centre and confirmed that the exact time of death was on May 14, 2016. 32. 33. 34. 35. Sunday, May 15, 2016, 20:23, the CBSA issued an approved media statement. Marketwired: Death of a CBSA Detainee Décès d'une personne détenue par l'ASFC News.gc : Death of a CBSA Detainee Décès d'une personne détenue par l'ASFC
Next Steps – Management ***Prochaines étapes – mesures à prendre par la direction***	36. CBSA Prairie Region will follow the established Death-in-Custody protocol and has commenced its fact-finding into the incident. 37.
Proposed Media Lines ***Infocapsules***	38. We can confirm that a Canada Border Services Agency (CBSA) detainee passed away on May 14, 2016, while under the care and control of Justice and Solicitor General of Alberta. 39. The identity of the individual, a 24-year-old man, will not be released at this time. 40. In the Prairie Region, the CBSA relies on provincial correctional facilities to detain

	higher-risk detainees. 41. As a result of the detainee's passing, an investigation is underway by the various responsible agencies and the CBSA will cooperate fully. 42. The CBSA is committed to ensuring the health and safety of those in its care. As is the case with any death in custody, the CBSA takes this matter seriously and will complete a review of the circumstances. 43. We can confirm that a Canada Border Services Agency (CBSA) detainee passed away on May 14, 2016, while under the care and control of the Edmonton Remand Centre. 44. In the Prairie Region, the CBSA relies on provincial correctional facilities to detain subjects on immigration hold. 45. As a result of the detainee's passing, an investigation is underway by the various responsible agencies and the CBSA will cooperate fully. 46. The CBSA is committed to ensuring the health and safety of those in our care. As is the case with any death in custody, the CBSA takes this matter seriously and will complete a review of the circumstances surrounding death.
This information is classified Protected A – Only for distribution internal to CBSA. ***Les renseignements fournis dans le présent document sont classifiés « Protégé A »; par conséquent, ils peuvent uniquement être communiqués à des employés de l'ASFC.***	

Issue Fact Sheet #2017-XXXX
Fiche d'information sur un enjeu #2017-XXXX

GTA - Death in custody at Milton District Hospital
RGT - Mort en garde à vue au l'hôpital du district de Milton

Issue Fact Sheets are tasked by the Issues Management Secretariat. For tracking purposes, Issue Fact Sheets are named and numbered by the Issues Management Secretariat when they are tasked to the office of primary interest (OPI).

Le Secrétariat de la gestion des questions confie aux bureaux de première responsabilité (BPR) la tâche de produire des fiches d'information sur la question, et fournit un titre et un numéro pour chacune d'entre elles à des fins de suivi.

Office of Primary Interest ***Bureau de première responsabilité***	Goran VRAGOVIC, Regional Director General, Greater Toronto Area (GTA) Region
Key Contact ***Personne-ressource***	Abeid MORGAN, Acting Director Enforcement and Intelligence Operations Division (EIOD), GTA Region
Supporting Offices of Collateral Interest ***Autres bureaux intéressés offrant un soutien***	Tyson GEORGE, Acting Assistant Director Hearings Unit, EIOD, GTA Region Jonathan KAMIN, Assistant Director Detentions and Operational Support, EIOD, GTA Region Martin Scott, Acting Director Corporate and Program Services Division, GTA Region
Date Issue Began ***Date de manifestation de l'enjeu***	*October 30, 2017*
Fact Sheet Creation Date ***Date de création de la fiche d'information***	*October 30, 2017*
Date Fact Sheet Updated ***Date à laquelle la fiche d'information a été mise à jour***	
Partners Consulted ***Partenaires consultés***	*Milton District Hospital*

	Ministry of Community Safety and Correctional Services (MCSCS) *Vanier Centre for Women (VCFW)* *Coroner's Office* *United States of America Consulate General in Toronto*
Supporting Documents ***Documents de référence***	*Case Summary* _Chrono.docx *Notification Letter to American Consulate* *Post-Mortem Examination Warrant from the Office of the Chief Coroner* OfficeofChiefCoroner_Warrant.pdf *Agreement between Canada and Ontario respecting detention of persons detained under the Immigration and Refugee Protection Act (IRPA)* 2015 AGREEMENT CBSA and MCSCS.pdf *Amended Agreement between Canada and Ontario respecting detention of persons detained under the IRPA* 2017 AMENDED AGREEMENT CBSA an
Key Facts ***Faits principaux***	**Sequence of Events:** 1. Ms. Teresa Michelle GRATTON (Universal Client Identification

	26. [redacted] 27. 28. 29. 30. 31. 32. 33. 34. At approximately 0947 hrs, Acting Assistant Director, Tyson GEORGE, was informed of Ms. GRATTON's death.

	42.
Considerations or Implications ***Considérations ou répercussions***	43. This is the third death-in-custody in the GTA Region involving a provincial correctional facility in the last two and half years. There may be questions on what safeguards are in place to protect the health and safety of detainees. 44. Questions may be raised as to why this individual, who was a Permanent Resident of Canada, with relatively minor criminality was detained in a provincial correction facility, where typically higher-risk inmates are held. 45. As per Schedule D, Section 6 of the Amending Agreement between Canada and Ontario respecting detention of persons detained under the IRPA, the province of Ontario is to forward any information in writing to the CBSA as soon as possible if health care staff at the provincial facility determine that the detainee represents a danger to themselves, other inmates, or staff. The province never contacted the CBSA to advise that the client was placed on suicide watch. 46. Potential for negative media coverage due to a death while in CBSA custody. Regional Communications is monitoring for any resultant media coverage of this matter. 47. Recent negative media coverage on how the CBSA has handled persons with mental health issues while in detention could resurface, and renew arguments that an independent oversight body is required.
Current Status ***Situation actuelle***	48. The GTA Region is awaiting confirmation from the Coroner's Office on whether an inquest will take place.
Next Steps – Management ***Prochaines étapes – mesures à prendre par la direction***	49. The GTA Region will follow the established Death-in-Custody protocol and has commenced its investigation into the incident. 50. GTA regional management will be following up with MCSCS officials to gather information about the incident, and to determine why the CBSA was not advised of the detainee being placed on suicide watch. 51. The GTA's Regional Communications unit is completing an 8(2)(m)(i) of the *Privacy Act* analysis. If release of additional information is

	approved based on the results of the 8(2)(m)(i) assessment, a second updated news release to provide information (such as the name of the deceased) will be considered. Additionally, this information will be provided reactively in response to media enquiries. 52. On 30OCT2017 at approximately 1500 hrs, a News Release was issued. http://www.newswire.ca/news-releases/death-of-a-cbsa-detainee-654148773.html http://www.newswire.ca/fr/news-releases/death-of-a-cbsa-detainee-654148773.html 53. GTA Regional management will be following up with MCSCS officials to determin
Media Lines ***Infocapsules***	54. We can confirm that a 50-year-old woman, detained for immigration purposes at the Vanier Centre for Women in Milton, Ontario passed away on October 30, 2017, while under the care and control of the Vanier Centre for Women. The family of the deceased has been notified and our thoughts are with them at this difficult time. 55. The CBSA is bound by the *Privacy Act* and other legislation, and the deceased's identity will not be released at this time. 56. As a result of the detainee's passing, an investigation has been launched by the various responsible provincial agencies and the CBSA is cooperating fully. 57. For questions about an inquest, please contact the Ministry of Community Safety and Correctional Services.
This information is classified Protected A – Only for distribution internal to CBSA. ***Les renseignements fournis dans le présent document sont classifiés « Protégé A »; par conséquent, ils peuvent uniquement être communiqués à des employés de l'ASFC.***	

Due Diligence Report on the In Custody Death

Completed by the Prairie Region

PROTECTED B

Version 4.0

Contents

Version Control Page

Version	Date	Changes
1.0	June 30, 2016	Initial Report to Vice-President, Operations Branch
2.0	July 11, 2016	Revision of Report to Vice-President, Operations Branch
3.0	November 28, 2016	Revision of Report to Vice-President, Operations Branch
4.0	January 30, 2017	Revision of Report to Vice-President, Operations Branch

Incident Summary

On the morning of May 15, 2016, at approximately 09:30 (MDT), a CBSA Inland Enforcement Officer in Edmonton received a telephone call from the admitting support staff at the ERC, indicating that at approximately 22:30 on May 14, 2016, was found non-responsive in his cell and had been pronounced dead. Information provided by the ERC indicated that the death did not appear to be the result of a suicide or foul play, and that the deceased's body was turned over to the medical examiner. There are no known cause(s) of death at this time.

Current Status

The CBSA has developed an Operational Bulletin OB PRG-2014-51 (http://atlas/pb-dgp/res/bulletins/bso-asf/2014/prg_2014_51_eng.asp) which outlines the procedures to be undertaken when CBSA has been notified that a person in IRPA custody has died while in detention. The Prairie Region will follow the established CBSA Death-in-Custody protocol and continue to update the Issue Fact Sheet (IFS), as required.

The Prairie Region has confirmed through the office of the provincial medical examiner that the official cause of death was In light of the circumstances (in custody death), it is mandatory that the medical examiner's findings be shared with the provincial review board. The provincial review board will determine if the matter warrants further action or if the file will be closed at this stage. The CBSA has no role in this process.

The Prairie Region held consultative meetings with stakeholders who house CBSA detainees. The initial intent of these meetings is to establish relations with key decision makers in these facilities in order to have open dialogue on issues of joint concern. Topics will include ensuring detention conditions are in compliance with domestic and international standards, regardless of the location of detention; placement of CBSA detainees in facilities (or locations in the facilities) given the specific and identified vulnerability faced by asylum seekers and migrants, particularly when placed in detention; general health, safety and wellbeing of CBSA detainees in said facilities; conditions of detentions, including access to medical service; and treatment of detainees, including complaint mechanisms and how they are actioned and notification to the CBSA. Stakeholder engagement is not an end in itself; specific engagement objectives such as these must be an integral part of our primary business objectives.

Prairie Region Enforcement and Intelligence Division (EIOD) has established a calendar of dates for consultation with key stakeholders; correctional facilities that house CBSA detainees. The following meetings have been scheduled and confirmed with the correctional centres.

Institution	Consultation Dates	Update
Calgary Remand Centre (CRC)	June 23, 2016 September 23, 2016	Notification protocol sent via email September 6, 2016. Alternatives to Detentions Stakeholder engagement session October 26, 2016.
Edmonton Remand Centre (ERC)	June 28, 2016 October 3, 2016	Notification protocol sent via email September 6, 2016. Alternatives to Detentions Stakeholder engagement session October 26, 2016.
Winnipeg Remand Centre	July 14, 2016	Notification protocol letter mailed September 7, 2016. Alternatives to Detentions Stakeholder engagement session October 28, 2016.
Pine Grove Correction Centre (women's centre)	July 11, 2016 August 16, 2016	Notification protocol sent via email September 13, 2016. Alternatives to Detentions stakeholder engagement session October 27, 2016.
Saskatoon Correction Centre (men's centre)	August 16, 2016 October 4, 2016	Notification protocol sent via email September 13, 2016. Alternatives to Detentions stakeholder engagement session October 27, 2016.

Institution	Consultation Dates	Update
Regina Correction Centre (men's centre)	August 16, 2016 October 5, 2016	Notification protocol sent via email September 13, 2016. Alternatives to Detentions stakeholder engagement session October 27, 2016.
Lethbridge, Red Deer and Medicine Hat Remand Centres, Alberta	None	Notification protocol letter mailed September 6, 2016. Meetings are not presently being pursued as currently there are no persons detained. (normally these centres experience low levels of Immigration)
Headingly and Milner Ridge Correctional Centres, Manitoba	July 14, 2016	Headingly representatives and advised they would brief Milner Ridge. Notification protocol letter mailed Alternatives to Detentions Stakeholder engagement sessions Oct 28, 2016 September 7, 2016.
United Nations High Commissioner for Refugees (UNHCR) at CRC	July 26, 2016	No further consultation scheduled.
UNHCR at ERC	July 27, 2016	No further consultation scheduled.

Discussions at the stakeholder meeting between the Prairie Region EIOD and the Edmonton Remand Centre (ERC) on June 28th, 2016 were also productive. The consultation centered on the death

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Conclusion

Issue #1

The CBSA has a Public Communications Protocol for In-Custody Death (http://atlas/cab-dgsi/res/toolkit-outils/media/sop_pne_eng.asp), which outlines pro-active and responsive media protocols to advise the public and manage enquiries to the death of a person in IRPA custody. A disparity has been identified between the roles and responsibilities of both headquarters and regional communications. Identification of NOK and privacy issues was identified as areas that needed tighter direction. NOK information was not available on the CBSA files; time was spent trying to determine NOK and further verification was required as to who is eligible to contact the NOK. In addition, privacy issues were also identified as a challenge, in that a determination had to be made as to what information could be shared with key stakeholders (example: Red Cross).

Recommendation #1

A renewed media protocol has been established and received approval from senior management in headquarters. It now ensures an effective and efficient process, addresses any shortfalls and provides clear direction to ensure the region is well positioned to deal with NOK and all privacy issues pursuant to such situations.

Issue #2

More regular stakeholder consultations between the CBSA and the Edmonton Remand Centre (ERC), which holds the CBSA detainees, need to take place. These engagement sessions will focus on enhancing the partnerships and shortfalls, such as notification protocols between the ERC and the CBSA. A concern lies with the length of time it took to advise the CBSA of the death of our detainee. In addition, roles and responsibilities of the EIOD Detention Liaison Officer (DLO) position need to be clarified.

Recommendation #2

The Prairie Region met with ERC on June 23, 2016. A notification protocol was established between the CBSA and ERC; the protocol was communicated via email on September 6, 2016. EIOD management met with the Executive Director of Alberta Justice and Solicitor General on October 5, 2016 to discuss the notification protocol, contact list, MOU, health exposure risks as it relates to EIOD staff. The CBSA has established contact and developed relationships with all of the necessary parties at the ERC in the event of a crisis with a CBSA detainee. Prairie Region has identified an EIOD Detention Liaison Officer (DLO), has defined their responsibilities and has shared this information with the ERC. The DLO has engaged the Canadian Bar Association (CBA) to obtain contact information for practicing immigration lawyers' to be posted in the ERC. Coordination with the Red Cross and the United Nations High Commissioner for Refugees (UNHCR) is occurring for upcoming detention monitoring visits.

Issue #3

Through the development of the Issue Fact Sheet (IFS), the Backgrounder and the Question Period Note (QPN), discrepancies with reporting and obtaining accurate and timely information from regional operations were identified.

Recommendation #3

For time efficiency and data accuracy, the Prairie Region has begun a process where case summaries, including NOK information, are updated and loaded into GCMS/NCMS. This will allow for information from the client's physical file to be uploaded to GCMS/NCMS, ensuring accuracy stemming from one shared source of information.

AUDIT OF DUE DILIGENCE REPORT – DEATH IN CUSTODY MANAGEMENT RESPONSE AND ACTION PLAN

RECOMMENDATION 1

The Canada Border Services Agency (CBSA) has a Public Communications Protocol for In-Custody Death (http://atlas/cab-dgsi/res/toolkit-outils/media/sop_pne_eng.asp) which outlines pro-active and responsive media protocols to advise the public and manage enquiries to the death of a person in *Immigration Refugee Protection Act (IRPA)* custody. The Prairie Region has identified a disparity between the roles and responsibilities of both headquarters and regional communications. Identification of Next of Kin (NOK) and privacy issues was also identified as areas that needed tighter direction. In addition, privacy issues were also identified as a challenge; a determination had to be made as to what information could be shared with key stakeholders.

1. The CBSA will ensure a renewed Public Communications Protocol for In-Custody Death is established to identify the roles and responsibilities of both headquarters and regional communications.
2. Tighter direction to be provided regarding identification of NOK and privacy issue; what information can be shared with stakeholders.

MANAGEMENT RESPONSE
Agreed. The CBSA will renew its Public Communications Protocol for In-Custody Death which outlines roles and responsibilities of both headquarters and regional communications when dealing with pro-active and responsive media protocols to advise the public and manage enquiries to the death of a person in *IRPA* custody. The Prairie Region identified tighter direction was required regarding NOK and privacy issues. A determination had to be made as to what information could be shared with key stakeholders.

MANAGEMENT ACTION PLAN	OPI	COMPLETION DATE
1. An updated CBSA Public Communications Protocol for In-Custody Death has been established and approved. It provides clear direction for roles and responsibilities for both headquarters and regional communications. The protocol ensures an effective and efficient process, addresses identified shortfalls and provides clear direction to regions to deal with NOK, privacy issues and sharing of information with stakeholders.	Brad Wozny	Completed

RECOMMENDATION 2

The Prairie Region will conduct more regular stakeholder consultations between the CBSA and the Edmonton Remand Centre (ERC), which holds the CBSA detainees. These engagement sessions will focus on enhancing the partnerships and shortfalls, such as notification protocols between the ERC and the CBSA. A concern lies with the length of time it took to advise the CBSA of the death of our detainee. In addition, roles and responsibilities of the Detention Liaison Officer (DLO) position need to be clarified.

- Schedule prepared for quarterly meetings. Local supervisors to report to senior management regarding action items resulting from engagement.
- Draft notification protocol awaiting endorsement from Alberta Correctional Department (ACD). The ACD covers all correctional facilities located in Alberta.
- Establish roles and responsibilities for the DLO.

MANAGEMENT RESPONSE.
Agreed. The Prairie Region will conduct regular stakeholder consultations between the CBSA and the Edmonton Remand Centre (ERC), which holds the CBSA detainees which will focus on enhancing the partnerships and shortfalls, such as notification protocols.

MANAGEMENT ACTION PLAN	OPI	COMPLETION DATE
1. Schedule established for quarterly meetings with ERC and other provincial correctional parties to enhance communication, collaboration and understanding of our clients in correctional facilities.	Mike Skappak	Completed
2. A formalized regional template is being established to replace the current tracking of the quarterly meetings, and ad hoc sessions. The report includes participants and any action items that result. A quarterly executive summary will be shared with the Regional Director General.	Mike Skappak	March 10, 2017
3. Notification Protocol was developed between CBSA and the provincial remand centres in September 2016. It establishes criteria/perimeters when the CBSA needs notification based on seriousness of incident. Awaiting final endorsement from the ACD.	Mike Skappak	March 03, 2017
4. The roles and responsibilities of the DLO position have been clarified and provided to officer currently occupying this position.	Mike Skappak	Completed

RECOMMENDATION 3

Through the development of the Issue Fact Sheet (IFS), the Backgrounder and the Question Period Note (QPN), the Canada Border Services Agency identified discrepancies with reporting and obtaining accurate and timely information from regional operations.

3. The CBSA Prairie Region will ensure that case summaries include NOK information that has been voluntarily provided by the subject. The information that is made available will be uploaded into the GCMS system to ensure accuracy reporting from one shared source of information.

MANAGEMENT RESPONSE
Agreed. The CBSA identified discrepancies with reporting and obtaining accurate and timely information from regional operations with the development of the IFS, the Backgrounder and the QPN. A detainee cannot be compelled to supply the NOK information; should the NOK information not be provided, it will not be available for the CBSA.

MANAGEMENT ACTION PLAN	OPI	COMPLETION DATE
1. Prairie Region established Standard Operating Procedures (SOPs) for uploading National Risk Assessment Documents (NRAD) and medical forms of detainees into GCMS.	Mike Skappak	Completed
2. A communications piece has been developed to introduce the SOPs to all staff and will be distributed.	Brad Wozny	March 01, 2017

Notification Protocol Between Canada Border Services Agency and Remand Centres

PURPOSE: The purpose of this protocol is to ensure appropriate communication channels exist to allow timely notifications between Canada Border Services Agency (CBSA) and Remand Centres.

APPLICATION: CBSA requests that timely notifications are made by Remand Centre officials regarding the status of detained CBSA clients in specified circumstances, as identified below in the Notification Process.

STAKEHOLDERS: Prairie Region CBSA Inland Enforcement offices (Calgary, Edmonton, Regina, Saskatoon, and Winnipeg) and relevant Prairie Region Remand Centres (Alberta, Saskatchewan, and Manitoba).

NOTIFICATION PROCESS:

Remand Centre to CBSA – Significant/Urgent Incidents:

1) In-custody death, grave injury, or suicide attempt that requires immediate medical attention

   - Contact 24-hour CBSA Enforcement and Intelligence Operations Division Duty Manager Pager immediately at

2) Violent behaviour, medical concerns, or mental health issues, including suicidal verbalizations, that may impact the safety or security of CBSA staff during transport or in a hearing.

   - Contact 24-hour CBSA Enforcement and Intelligence Operations Division Duty Manager Pager immediately at

3) Serious injury in-custody

   - Contact 24-hour CBSA Enforcement and Intelligence Operations Division Duty Manager Pager immediately at

Remand Centre to CBSA – Significant/Non-Urgent Incidents

4) Hunger strikes where the client has stated that they are on a hunger strike or are determined to be on a hunger strike by Remand Centre staff.

   - Contact local Manager by phone and email local Inland Enforcement Inbox by no later than next business day

Canada

5) Inter-facility movement of clients

   - Email local Inland Enforcement Inbox by no later than next business day

6) Violent behaviour, medical concerns, or mental health issues that may impact the decision to detain a client and/or to coordinate and facilitate the removal process

   - Email local Inland Enforcement Inbox by no later than next business day

7) Other

   - Contact appropriate CBSA representative as and when deemed necessary

CBSA to Remand Centre

1) Violent behaviour, medical concerns, or mental health issues, including suicidal verbalizations, that may impact the safety or security of Remand Centre staff and/or proper intake and placement of a client

   - Contact appropriate Remand Centre unit (e.g. Admission & Discharge or Health Unit) immediately by telephone and follow up with written notification

2) Other

   - Contact appropriate Remand Centre representative as and when deemed necessary

CONTACT INFORMATION:

Location	Contact Name	Position	Phone Number	Email Address
Calgary Inland Enforcement	Inbox			Calgary.Enforcement@cbsa-asfc.gc.ca
	Karen Wilmot	Manager	403-292-5978	Karen.Wilmot@cbsa-asfc.gc.ca
	Tammy McKnight	Supervisor	403-292-5740	Tammy.McKnight@cbsa-asfc.gc.ca
	Geoff Martin	Supervisor	403-292-4736	Geoffrey.Martin@cbsa-asfc.gc.ca
Edmonton Inland Enforcement	Inbox			Edmonton.Enforcement@cbsa.gc.ca
	Kristine Conroy	A/Manager	780-495-2105	Kristine.Conroy@cbsa-asfc.gc.ca
Regina Inland Enforcement	Inbox			Regina.enforcement@cbsa-asfc.gc.ca
	Chris Case	A/Manager	306-780-7593	Chris.Case@cbsa-asfc.gc.ca
Saskatoon Inland Enforcement	Inbox			Saskatoon.enforcement@cbsa-asfc.gc.ca
	Chris Case	A/Manager	306-780-7593	Chris.Case@cbsa-asfc.gc.ca
Winnipeg Inland Enforcement	Inbox			Winnipeg.Enforcement@cbsa-asfg.gc.ca
	Matthew Chammartin	Manager	204-983-4671	Matthew.Chammartin@cbsa-asfc.gc.ca
EIOD Duty Manager	Pager		403-292-6592	
Senior Management	Mike Skappak	Director	403-292-4058	Mike.Skappak@cbsa-asfc.gc.ca
	Andrew Klatt	Assistant Director	204-983-2188	Andrew.Klatt@cbsa-asfc.gc.ca
	Bill Axten	Assistant Director	403-292-6655	Bill.Axten@cbsa-asfc.gc.ca

UPDATES: To be reviewed and updated on a quarterly basis to ensure contact information remains current.

Last Revised: August 24, 2016

Institution	Contact Names	Local Manager	Frequency of Meetings	Comments
		Alberta		
Calgary Remand Centre		Calgary Inland Manager: Karen Wilmot 403-292-5978 Assistant Director: Andrew Klatt 204-983-2188	Quarterly: next meeting set for June 23, 2016	All of these facilities house both males and females. The Calgary and Edmonton Remand Centre house all of our detainees who will attend a detention review. Occasionally arrests on CBSA authority are made outside the Calgary area and the detainee may be housed for 1-3 days in the Medicine Hat Remand, Lethbridge Correctional Centre, or the Red Deer Remand. Additionally any arrests made at the land border where detention is sought, will send their detainee to the Lethbridge Correctional Centre. However, 99 percent of our billed clients' detention days are from the Calgary and Edmonton Remand Centres. The first meetings scheduled for the Edmonton and Calgary Remand Centres will focus on in custody death.
Lethbridge Correctional Centre		Calgary Inland Manager: Karen Wilmot 403-292-5978 Assistant Director: Andrew Klatt 204-983-2188	Annually	
Red Deer Remand Centre		Calgary Inland Manager: Karen Wilmot 403-292-5978 Assistant Director: Andrew Klatt 204-983-2188	Annually	
Medicine Hat Remand Centre		Calgary Inland Manager: Karen Wilmot 403-292-5978 Assistant Director: Andrew Klatt 204-983-2188	Annually	
Edmonton Remand Centre		Edmonton Inland Manager: Olivia Millson 780-495-6785 Assistant Director: Andrew Klatt 204-983-2188	Quarterly: next meeting set for July 14, 2016.	
		Manitoba		
Winnipeg Remand Centre		Winnipeg Inland Manager: Matthew Chammartin 204-983-4671 Assistant Director: Andrew Klatt 204-983-2188	Quarterly: next meeting set for July 14, 2016.	Winnipeg Remand Centre is responsible for 90 percent of our initial detentions. First meeting with Winnipeg Remand Centre will focus on in custody deaths. Messages have been left at the other institutions and we will attempt to coordinate a discussion with them to set up meetings in June/July.
Headingley Correctional Centre		Winnipeg Inland Manager: Matthew Chammartin 204-983-4671 Assistant Director: Andrew Klatt 204-983-2188	Quarterly:	
Milner Ridge Correctional Centre		Winnipeg Inland Manager: Matthew Chammartin 204-983-4671 Assistant Director: Andrew Klatt 204-983-2188	Quarterly:	

		Saskatchewan		
Saskatoon Correction Centre (men's facility)		A/Sask Inland Manager: Chris Case 306-780-7593 Assistant Director: Andrew Klatt 204-983-2188	Quarterly: next meeting set for Oct 4, 2016	Conference call set for July 11, 2016 with the Directors from all three Correction centres to discuss in-custody deaths with A/Manager Chris Case and Assistant Director Andrew Klatt. First meeting will focus on in custody deaths.
Regina Correction Centre (men's facility)		A/Sask Inland Manager: Chris Case 306-780-7593 Assistant Director: Andrew Klatt 204-983-2188	Quarterly: next meeting set tentatively for Oct 5, 2016.	
Pine Grove Correction Centre (women's centre)		A/Sask Inland Manager: Chris Case 306-780-7593 Assistant Director: Andrew Klatt 204-983-2188	Annually: TBD	

Date: May 16, 2016
Classification: Unclassified
Branch / Agency: Operations Branch /CBSA

Question Period Note / Note pour la Période des questions

DEATH OF A CANADA BORDER SERVICES AGENCY DETAINEE WHILE IN CUSTODY – MAY 2016

ISSUE: The death of a Canada Border Services Agency (CBSA) client while under the care and control of the Edmonton Remand Centre

BACKGROUND:

On May 15, 2016, the Canada Border Services Agency (CBSA) was notified by the Justice and Solicitor General of Alberta that an individual detained under the *Immigration and Refugee Protection Act* at the Edmonton Remand Centre had passed away on May 14, 2016.

The name of the individual, a 24 year old man, is personal information and as such is protected under the Privacy Act. Privacy legislation prevents any detailed discussion regarding the details of this case.

The CBSA is committed to ensuring the health and safety of those in our care. As is the case with any death in custody, the CBSA takes the matter seriously and will complete a review of the circumstances surrounding the death to identify any factors that could be addressed to prevent any future loss of life.

The CBSA will fully cooperate with the investigation initiated by the various agencies into the details surrounding this case.

DEATH OF A CANADA BORDER SERVICES AGENCY DETAINEE WHILE IN CUSTODY – MAY 2016

PROPOSED RESPONSE:

- **Privacy legislation prevents me from discussing the complete details of a person's case.**

- **I can confirm that a Canada Border Services Agency detainee passed away on May 14, 2016, while under the care and control of the Edmonton Remand Center.**

- **The identity of the individual, a 24 year old man, will not be released at this time.**

- **In the Prairie Region (Manitoba, Saskatchewan & Alberta), the Canada Border Services Agency relies on provincial correctional facilities to detain higher-risk detainees.**

- **As a result of the detainee's passing, an investigation is underway by the various responsible agencies and the Canada Border Services Agency will cooperate fully.**

- **The Canada Border Services Agency is committed to ensuring the health and safety of those under detention. The protocol with all deaths in custody is to complete a review of the circumstances surrounding this death.**

CONTACTS:			
Prepared by Kim Scoville , Regional Director General, Prairie Region, Operations Branch	Tel. no. 204-983-3758	Approved by Caroline Xavier Vice-President, Operations Branch	Tel. no. 613-952-5269

Young, Andrew

From: CBSA-ASFC_Border Operations Centre-Centre des Opérations Frontalières
Sent: March 14, 2016 10:39 AM
To: CBSA-ASFC-Dist_IRC_Med; CBSA-ASFC-DIST_GTAR_Dist_Dir-Dir_dist; CBSA-ASFC-Dist_IRC_SMan
Cc: CBSA-ASFC_Border Operations Centre-Centre des Opérations Frontalières
Subject: Amendment - Medical: CBSA detainee on court hold found deceased at provincial detention centre - D1006578

Categories: CJP129

Significant Event – D1006578 AMENDMENT
Border Operations Centre (BOC)
Le Centre des opérations frontalières (COF)

Duty Executives are to inform appropriate units within their branch or region.
Les cadres de service doivent informer les secteurs appropriés de leur direction générale ou région.

Amendment –
Further details have been provided regarding the timeline of this event. The CBSA was notified at approximately 0905 ET on March 13, 2016 that the client had been taken to hospital from the correctional facility. At approximately 0915 ET, the CBSA was notified that the client had been declared deceased at 0904 ET, March 13, 2016 and that Halton Regional Police would assume responsibility for the investigation into the death.

Synopsis –
On March 13, 2016, the BOC was notified at 2016 ET that a foreign national in detention at the Maplehurst Correctional Complex was found with no vital signs on the morning of March 13, 2016, and was taken to Milton District Hospital where he was declared deceased.

Impact –
The situation could attract media attention.

CBSA Action/Next Steps
At this time, cause of death is unknown. Halton Regional Police have begun an investigation into the death, and are currently working with CBSA to contact the next of kin of the deceased. The CBSA is in the process of contacting the in Ottawa. Additional updates will be provided as information is received.

Source –
Steve Sokiryansky – Enforcement Supervisor, Inland Enforcement EIOD, Greater Toronto Area Region

This notification was provided on behalf of Duty Executive Steve Gorham.

This information is classified Protected A. Only for distribution internal to CBSA. If you have any questions or follow up requests for detailed information, please contact the Border Operations Centre at

BOC Officer
Claude Provost

BOC Supervisor
Dara Roberts

Young, Andrew

From: CBSA-ASFC_Border Operations Centre-Centre des Opérations Frontalières
Sent: October 30, 2017 10:50 AM
To: CBSA-ASFC-Dist_IRC_Med; CBSA-ASFC-DIST_GTAR_Dist_Dir-Dir_dist; CBSA-ASFC-Dist_IRC_SMan
Cc: CBSA-ASFC_Border Operations Centre-Centre des Opérations Frontalières
Subject: Amended/Concluded: Medical Incident resulting in death at Toronto Vanier Centre for Women - S1008460

Categories: MXB070

Significant Event – S1008460 CONCLUDED
Border Operations Centre (BOC)
Le Centre des opérations frontalières (COF)

Duty Executives are to inform appropriate units within their branch or region.
Les cadres de service doivent informer les secteurs appropriés de leur direction générale ou région.

Amendment –
On October 30, 2017, at 1038 ET, the BOC was informed that the coroner updated time of death to 0927 ET.

Conclusion –
On October 30, 2017, at 0956 ET, the BOC was informed that the client had passed away. The client was pronounced dead at 0925 ET.

CBSA is now attempting to contact next of kin. The client was detained under immigration hold at Vanier Centre for Women (correctional facility) awaiting an admissibility hearing.

Synopsis -
On October 30, 2017, at 0801 ET, the BOC was informed that Enforcement and Intelligence Operations Division received information from Vanier Centre for Women that a permanent resident, currently detained under immigration hold and awaiting an admissibility hearing, was sent to Milton Hospital after

Impact -

CBSA Action/Next Steps -
The BOC will provide updates as they become available.

Source -
Steve Sokiryansky, Inland Enforcement Supervisor, Greater Toronto Area Region
Sajjad Bhatti, Manager Regional Programs, Greater Toronto Area Region

This notification was provided on behalf of Duty Executive Lynne Lamarche.

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BOC Officer
Marjolaine Brault-Roy

BOC Supervisor
Dara Roberts

Young, Andrew

From: CBSA-ASFC_Border Operations Centre-Centre des Opérations Frontalières
Sent: March 7, 2016 11:52 PM
To: CBSA-ASFC-Dist_IRC_Med; CBSA-ASFC-DIST_GTAR_Dist_Dir-Dir_dist; CBSA-ASFC-Dist_IRC_SMan
Cc: CBSA-ASFC_Border Operations Centre-Centre des Opérations Frontalières
Subject: New/ Concluded - Medical - Detainee at TEDC deceased - D1006556

Follow Up Flag: Follow up
Flag Status: Completed

Categories: rrh702

Significant Event – D1006556 NEW/CONCLUDED
Border Operations Centre (BOC)
Le Centre des opérations frontalières (COF)

Duty Executives are to inform appropriate units within their branch or region.
Les cadres de service doivent informer les secteurs appropriés de leur direction générale ou région.

Synopsis –
On March 7, 2016, the BOC was notified at 2256 ET, by the Toronto Inland Enforcement Supervisor that Toronto East Detention Centre (TEDC) have advised that an immigration detainee in their custody was found in medical distress in the psychiatric wing of the institution. Nurses and Paramedics attempted to revive the detainee who has since been pronounced deceased. CBSA has contacted in Toronto by phone and written notification to inform of the subject's passing. CBSA is currently working with our police partners in order to identify and notify the subject's next of kin.

Impact –
No impact to operations at this time.

CBSA Action/Next Steps
The BOC considers this event concluded

Source –
Steve Sokiryansky – Enforcement Supervisor, Inland Enforcement EIOD, Greater Toronto Area Region

This notification was provided on behalf of Duty Executive Tracy Annett.

This information is classified Protected A. Only for distribution internal to CBSA. If you have any questions or follow up requests for detailed information, please contact the Border Operations Centre at

BOC Officer
Bob Hickson

BOC Supervisor
Brian Murray

FOR INFORMATION

FOR THE PRESIDENT

In-Custody Death

CONTEXT

On October 30, 2017, a CBSA detainee that was under the care and control of the Vanier Centre for Women, a provincial detention facility located in Milton, Ontario, died from a suspected drug overdose.

This is the third in-custody death in the Greater Toronto Area (GTA) Region involving a provincial correctional facility in the last two and half years.

There is potential for negative media coverage due to a death of an individual while in the custody of the CBSA.

BORDER OPERATIONS INPUT/ANALYSIS

Persons who are not suitable for detention at a CBSA Immigration Holding Centre, including those who have serious mental health issues, as well as those who pose a danger to themselves or others, are transferred to a provincial correctional facility.

As per Schedule D, Section 6 of the Amending Agreement between Canada and Ontario respecting detention of persons detained under the *Immigration and Refugee Protection Act (IRPA)*, the province of Ontario is to forward any information in writing to the CBSA as soon as possible if health care staff at the provincial facility determine that the detainee represents a danger to themselves, other inmates, or staff. They are to describe the nature of the risk, which include suicidal tendencies, contagious disease, and serious mental illness.

The National Risk Assessment for Detention (NRAD) was completed by the Southern Ontario Region on September 29, 2017. The hard-copy version of the NRAD is being located to understand the decision as to why the detainee, with minor criminality, was detained in a provincial correction facility.

CONSIDERATIONS

With this recent death-in-custody at a provincial correctional facility, there may be questions on what safeguards are in place to protect the health and safety of detainees.

Negative media coverage on how the CBSA manages persons with mental health issues while in detention could likely resurface, and renew arguments that an independent oversight body is required.

The GTA Region will follow the established Death-in-Custody protocol and has commenced its investigation into the incident. The Region is awaiting confirmation from the Coroner's Office on whether an inquest will take place..

A news release was sent out, as per the Public Communications Protocol, advising of the incident. The GTA Region is completing an Public Interest Disclosure analysis under 8(2)(m)(i) of the *Privacy Act.* If release of additional information is approved based on the results of the 8(2)(m)(i) assessment, a second updated news release to provide information (such as the name of the deceased) will be considered.

SUGGESTED SPEAKING NOTES/INVERVENTIONS (AS NECESSARY)

The CBSA is committed to ensuring the health and safety of those under detention. As is the case with all CBSA in-custody injuries and deaths, the CBSA will complete a review of the circumstances, and will fully cooperate with any investigations launched by responsible agencies.

The CBSA is bound by the *Privacy Act* and other legislation, and is unable to release the name of the detainee who has died in custody as it is considered personal information. Family of the deceased has been notified.

Lead Director/Director General: Goran Vragovic, Regional Director General

Annex 1 –Management Response Action Plan (MRAP)

In-Custody Death at the Milton District Hospital

OVERALL MANAGEMENT RESPONSE

Following the regional review of the events leading to the in-custody death of at the **Milton District** Hospital, the After-Incident Review Working Group delivered an After Incident Report and the Greater Toronto Area Region (GTAR) delivered an In-Custody Death Due Diligence Report (DDR). This MRAP addresses the report's recommendations in order to strengthen relevant national policies, guidelines and directives.

Observation #1:

Despite established detention Memoranda of Understandings (MOU) with provincial partners and policy and operational guidance within CBSA Enforcement manuals, the following policies and procedures remain unclear and therefore lead to inconsistent use and application:,

- When and how outstanding immigration warrants are to be executed for individuals that are detained under a different Act of Parliament;
- When a detention order is to be issued against an individual who is arrested and in detention under a different Act of Parliament;
- How detainees are to be delivered into CBSA custody (at the expiration of their terms of court hold); and
- The use and application of section A59 of the *Immigration Refugee Protection Act (IPRA)*, which relates to incarcerated foreign nationals and/or permanent residents. More specifically the transfer of inmates into CBSA custody at the end of their period of detention under a different Act of Parliament.

RECOMMENDATION #1
CBSA NHQ to fully examine policies and operational protocols related to the issuance of a warrant and a detention order for an individual incarcerated under another Act of Parliament. Further explore the use of A59 and its use and application across Canada. Identify policy gaps that may be addressed through revised guidance to the field. Identify whether this review will have impacts and require amendments to MOUs with provincial partners.

MANAGEMENT RESPONSE	
Management agrees with this recommendation.	
MANAGEMENT ACTION PLAN	**COMPLETION DATE**
EIOD-HQ, in consultation with EIPD-HQ, to facilitate a meeting with GTAR, SOR and the NOR enforcement and intelligence divisions to examine and resolve any outstanding operational issues, as well as developing a process for admission for complex cases at the Toronto IHC from other regions.	May 15, 2018
EIPD-HQ to undertake a review and procedures on the use of section A59 of the *IRPA* and make recommendations to improve its consistent application on a national scale.	Fall 2018
EIPD-HQ to review current forms/tools employed by the regions for arrests and detention, to determine if any updates are required.	Fall 2018
EIOD-HQ to establish a national standardized checklist that will assist managers in conducting reviews of arrest files and will establish national operational consistency.	June 29, 2018
GTAR to develop business processes and procedures in accordance with national directives related to the transfer of custody from one detaining authority to another, and notifications to relevant parties (i.e. duty managers).	September 1, 2018
GTAR to update the local checklist to assist managers in conducting reviews of arrest files with input from all regions, including POEs, transferring detainees to the GTA IHC.	Completed December 21, 2017

Observation #2:

According to the DDR, there appears to have been no involvement by the Detention Liaison Officer (DLO) in this particular case […]

RECOMMENDATION #2
Finalize drafted DLO position profile and functions and ensure consistent national implementation.

MANAGEMENT RESPONSE	
Management concurs with the recommendation. Regions have elected to implement the DLO functions differently, so further clarity around these activities and who will undertake them requires standardization.	
MANAGEMENT ACTION PLAN	**COMPLETION DATE**
EIOD-HQ to engage the regions to validate the finalized DLO position profile.	May 1, 2018
EIOD-HQ to establish a standard approach for the implementation of the DLO position to ensure national consistency.	June 30, 2018

Observation #3:

[…] Additional consideration to where an individual is in the immigration process and how this may impact the CBSA's ability to achieve an enforcement outcome, should be further clarified and evident in officer decision-making.

RECOMMENDATION #3
ENF 20 to be revised to clarify the use of detention and its linkage to the CBSA's ability to achieve an enforcement outcome. In addition, ENF 7 should be updated to ensure there is supplemental guidance pertaining to the importance of effective note-taking and documentation for investigations and arrests.

MANAGEMENT RESPONSE	
Management agrees with the recommendation.	
MANAGEMENT ACTION PLAN	**COMPLETION DATE**
EIPD-HQ, in consultation with EIOD-HQ, to update and finalize revisions to ENF 20. Specific updates are related to the issuance of a detention order (how and when); what constitutes a timely enforcement outcome and its' consideration into a detention decision; and how	June 30, 2018

vulnerabilities should be considered in relation to a detention or a release decision.	
EIPD-HQ, in consultation with EIOD-HQ, to review and update ENF 7 on investigations and arrest, more specifically the importance of adequate documentation and note-taking for cases related to Permanent Residents.	September 30, 2018

Observation #4

Despite the existence of a viable Alternatives to Detention (ATD) program provided by the Toronto Bail Program (TBP) in the GTA, current program parameters preclude the participation of individuals who are not subject to a removal order. In this particular case, the individual was subject to an outstanding admissibility hearing and as a result, she was not eligible for ATD programming based on administrative eligibility criteria […]

RECOMMENDATION #4
As part of the NIDF, the new ATD Framework should include clear eligibility parameters that are inclusive of all populations that may be subject to a detention decision.

MANAGEMENT RESPONSE	
Management agrees with the above recommendation and seeks to ensure applicability of ATDs in all circumstances and cases.	
MANAGEMENT ACTION PLAN	**COMPLETION DATE**
EIPD-HQ to develop robust eligibility guidelines for officer consideration when assessing the viability of referring an individual to an ATD, specifically Community Case Management and Supervision programming, and that these guidelines do not limit program participation based on immigration status, but rather case specific considerations. In conjunction with the above, EIPD-HQ to develop and deliver national training to all IEO staff on the use of ATDs and considerations for risk offset, particularly for those with identified vulnerabilities.	June 22, 2018

Observation #5

Regional management oversight of detention files appears to be limited. In addition to the Long Term Detention (LTD) Governance Process (January 2017), the Detention oversight and governance directives (4.1 & 4.2) and the finalization of a joint EIOD/EIPD Detention governance Action Plan (4.3), oversight should be improved at the stage of initial detention decision review. […]

RECOMMENDATION #5
Develop and implement a national detentions QAP to improve program integrity that would lay the groundwork for policy guidance and protocols through regular QA reviews by regional management and the CBSA's NHQ.

MANAGEMENT RESPONSE	
Management concurs and views this as a best practice.	
MANAGEMENT ACTION PLAN	**COMPLETION DATE**
GTAR to develop region specific procedures to ensure alignment and implementation of national policies and directives related to detention oversight and decision-making.	Completed December 21, 2017
GTAR to review all active detention cases to ensure alignment with national directives and policies related to the capturing and storage of information in the NCMS and GCMS (i.e.: National Risk Assessment for Detention (NRAD) and Detention Medical Form (DMF) uploaded correctly).	April 6, 2018
GTAR to implement regional processes aligned with national direction on detention oversight and governance, and ensure that regular file reviews are undertaken to ensure completeness of officer notes and notes to file.	April 30, 2018
EIOD-HQ to develop options for a future national QAP.	May 11, 2018
EIOD-HQ to implement a formal national QAP that can review detentions program activities as a whole.	June 15, 2018

Observation #6

When an officer is making a detention decision, they must weigh the factors associated with that specific case against the risk the individual may pose if released to the community or the risk of them failing to appear for future immigration processes. […]

RECOMMENDATION #6
Update current products such as forms and manuals to ensure that vulnerability factors, such as mental health, are considered when determining if a detention is warranted. This should also be considered when determining the most appropriate facility/placement for detention and if continued detention is necessary.

MANAGEMENT RESPONSE	
Management agrees with the recommendation as it supports the NIDF mental health pillar.	
MANAGEMENT ACTION PLAN	**COMPLETION DATE**
EIPD-HQ to revise the NRAD and DMF forms to ensure vulnerability factors are included in an officer's assessment of detention placement.	Completed February 12, 2018
EIPD-HQ to provide training to CBSA employees in the GTA region who exercise arrest and detention authorities under the *IRPA,* on the use of the NRAD and DMF forms.	Completed February 12, 2018

Canada Border Services Agency | Agence des services frontaliers du Canada

After Incident Report

In-Custody Death at the Milton District Hospital

Protected B

PROTECTION • SERVICE • INTEGRITY

Canada

FINAL – February 14, 2018

Contents

Version Control Page

VERSION	DATE	CHANGES
v.1	29 January 2018	Initial draft completed
v.2	30 January 2018	Draft updated to include feedback from Leah Campbell
v.3	09 February 2018	Final draft with feedback from AIRWG members
v.4	14 February 2018	Incorporated final changes from AIRWG members
	9 April 2018	EIOD Review in Track Changes

Prepared by:

Aileen Girouard Senior Program Advisor
Detentions Program, HQ

Finalized by: Title

~~XXXXXXXX~~Josée Gaudreau A/Senior Program Advisor
Inland Enforcement Operations, HQ

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1.0 Purpose

Following a death in custody, an *After Incident Report* (AIR) is produced by the Canada Border Services Agency (CBSA) - Headquarters (HQ). The report provides a national perspective and observations on whether Agency policies and procedures were followed with respect to the care and custody of the deceased. It also takes corrective action if shortfalls are identified to prevent further occurrences in the form of a *Management Response Action Plan* (MRAP, Annex 1).

2.0 Summary of Incident

3.0 Background

3.1 Overview of the CBSA's Immigration Detention Program

In order to protect the safety, health and security of Canadians and the integrity of our border, the IRPA permits the CBSA to detain individuals. When making detention decisions, CBSA officers are guided by Canada's immigration laws and regulations, as well as by CBSA's detention guidelines and national standards. Detention is an enforcement tool to ensure the safety, health and security of the Canadian public, and immigration detention is always considered a measure of last resort. The detention guidelines contained in Enforcement Manual Chapter 20 require officers to consider all reasonable alternatives before detaining someone for immigration purposes. The CBSA relies on a variety of appropriate Alternatives to Detention (ATDs) where risks can be mitigated and where options exist such as: release with conditions; in-person or telephone reporting requirements; community case management & supervision (Toronto Bail Program (TBP)) and/or a cash bond; and/or a guarantee. Pursuant to the IRPA, detention can occur when:

1. A CBSA officer has reasonable grounds to believe that the person is inadmissible, and:
   - could pose a danger to the public;
   - is unlikely to appear for immigration proceedings; or
   - identity has not been established.

2. A CBSA officer has reasonable grounds to suspect, at a port of entry, that the person is inadmissible for security reasons, violating human or international rights, serious criminality, criminality or organized criminality.

3. It is necessary to complete the immigration examination.

4. A foreign national is designated as an irregular arrival by the Minister of Public Safety and Emergency Preparedness.

Detention decisions may be reviewed by the CBSA up to 48 hours after the person was detained. The CBSA may release the person and impose conditions for their release. After 48 hours, detention is reviewed by the Immigration and Refugee Board (IRB), an independent quasi-judicial tribunal. Detention is then reviewed seven days and every 30 days thereafter. A different detention review schedule exists for designated foreign nationals. In these cases, detention is mandatory and detention reviews take place within 14 days, then every six months. Detention will continue until a final positive decision is made by the IRB on a refugee claim, or until release is ordered by the IRB or the Minister. Excluded from the mandatory detention scheme are designated foreign nationals under the age of 16 (A55 (3)(1)).

In order to support officers and management, and to consistently evaluate detainee risk, the CBSA has developed a standardized tool referred to as the National Risk Assessment for Detention (NRAD) implemented on September 24, 2014 and recently revised for a re-launch on February 12, 2018. The revised NRAD form establishes Risk and Vulnerability Factors for individuals being considered for detention. Vulnerable groups are defined as pregnant women and nursing mothers; minors (under 18 years of age); persons with a severe medical condition, disability and/or restricted mobility who cannot be accommodated at the admitting detention facility; persons with suspected or known mental illness; and victims of human trafficking. Procedures for the NRAD require an internal CBSA reassessment of every detained case at least every 60 days after the initial assessment, in response to changes to the detainee's overall condition or a change in detention location and consideration of ATDs. This process also provides for regular monitoring. The individual is informed of the Risk and/or Vulnerably Factors that were taken into account and afforded an opportunity to make comments before the facility type recommended has been finalized following each assessment. While the officer is not bound by those comments are be taken into consideration as per existing detention policies. In conjunction with the NRAD, officers must complete a

Detainee Medical form[1] when a decision is made to transfer an individual to an admitting detention facility. A copy of the form is provided to the detention facility upon admission, noting that each receiving facility has their own admissions process that involves a medical examination. The Detainee Medical form contains general health and medical information provided by the detainee such as serious medical and/or mental health issues. A new Detainee Medical form must be completed by an officer every 45 days after the initial completion or at any point prior to the 45 day requirement when a detainee self identifies a change in medical/health condition or when a change in medical condition is observed by any custodial staff. As of February 12, 2018, the timeline has shifted to every 60 days to align to the subsequent NRAD review.

The Detainee Medical and NRAD forms contain information gathered from the detainee and from officer observations; neither are prepared by a medical professional. In combination, these tools serve to provide an initial indication of risk factors that may influence an individual's behaviour and potential to be managed in an IHC. Information about the detainee's overall health and medical condition as assessed by a medical practitioner is confidential and can only be viewed and shared by medical professionals on a need to know basis, e.g. when a detainee is transferred from a provincial facility to an IHC or vice versa; or with a signed consent to release by the individual concerned.

Immigration detainees have access to basic medical services via the Interim Federal Health Program or covered under a provincial health care program.

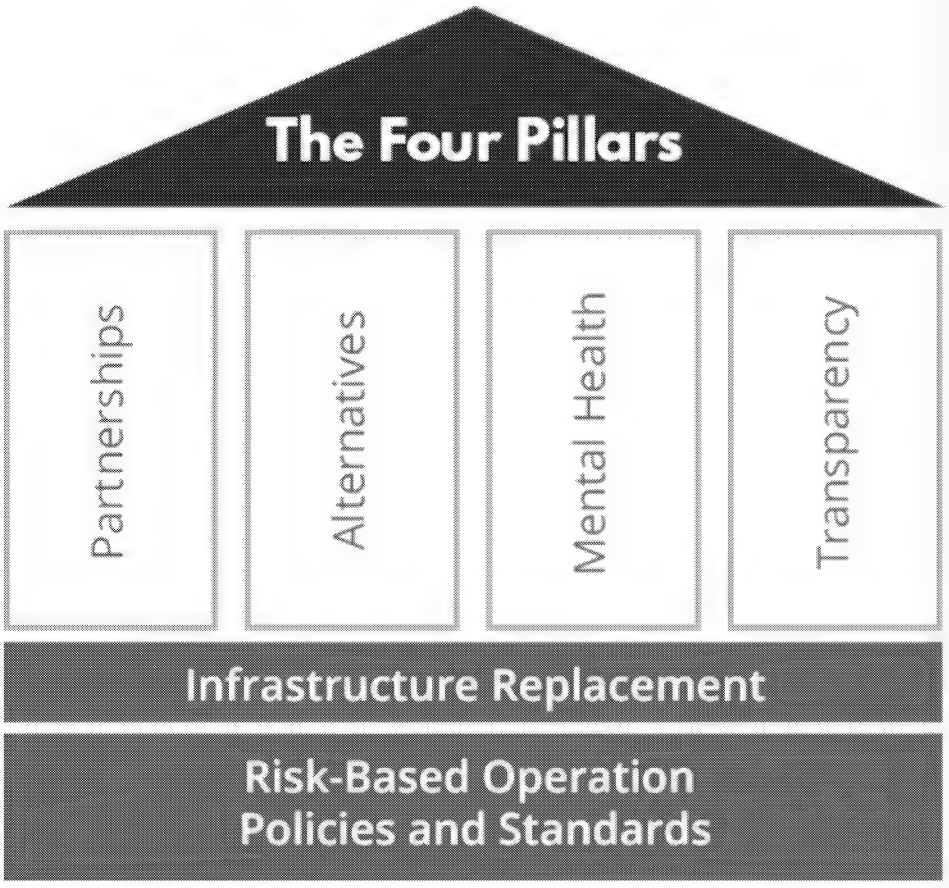
Individuals are currently detained in either a CBSA Immigration Holding Centre (IHC) in Laval, Quebec; Toronto, Ontario; a short-term facility in Vancouver, British Columbia; or in a provincial correctional facility (refer to Section 3.2). Upon an individual's arrest and/or transfer of custody, the CBSA has a legal obligation to inform detainees of their legal rights such as the right to be informed of the reason for the arrest and detention; the right to obtain counsel; the right to contact a representative of their government or the United Nations High Commissioner for Refugees (UNHCR).

For the operation of its IHCs, the CBSA maintains National Detention Standards that conform to international protocols such as a daily minimum of one hour open air exercise, free local telephone calls, access to a qualified religious representative upon request, and special meals provided for medical, dental or religious reasons.

On August 15, 2016, the Government of Canada committed an investment of up to $138 million to transform the immigration detention system. The National Immigration

[1] The "Detainee Medical form" was implemented on September 24, 2014 and recently revised for a re-launch on February 12, 2018 (renamed the Detainee Medical Needs form).

Detention Framework (NIDF) was launched to enhance ATDs, provide better mental and medical health services at IHCs, expand partnerships, and improve detention infrastructure. The NIDF furthers the fair treatment of individuals commensurate with their risk. Outcomes in the renewed system include safe, secure and better detention conditions; improved detainee well-being; consistent, risk-based national programming; and a detention program that is sustainable and affordable. The four pillars of the NIDF are illustrated below:



3.2 Use of Provincial Detention Facilities

The CBSA continues to pursue the establishment and maintenance of Memoranda of Understanding (MOUs) with individual provinces that can take the form of an Exchange of Letters, an Arrangement (legally non-binding) or Agreement (legally binding). The CBSA currently has Agreements with Alberta (2005 – to be updated), Ontario (2013), and Quebec (2017); and an Arrangement with British Columbia (2017). They address issues such as transfer of custody; transportation of detainees; minimized commingling; access/visits by non-governmental/international organizations and legal counsel; dispute-resolution processes; financial arrangements; and, information exchange within respective legal frameworks, including personal medical/mental/physical alert provisions. The CBSA relies on provincial correctional facilities to detain higher-risk detainees; lower-risk detainees in areas not served by an IHC; and for those detained for over 48 hours in the Vancouver area.

A review of the Agreement with Ontario was undertaken between July 2016 and February 2017 resulting in an Amending Agreement with a new Medical Information Sharing Arrangement/Schedule D and Contact List/Schedule E. Schedule D also addressed two of four recommendations within the HQ *Management Response and Action Plan for the Incident at the Niagara Detention Centre (2014)*: 1) To develop an information sharing agreement with Ontario; and, 2) To share relevant incident-related information between the two parties. Overall, the amendments affirmed the CBSA's commitment to strengthen continuity of care and the general well-being of IRPA detainees while reinforcing two central pillars of the NIDF: Mental Health and Partnerships.

3.3 Program Integrity and Independent Monitoring

Impartial monitoring of Canada's immigration detention program is critical to supporting the Government of Canada's commitment to respecting human rights while upholding the rule of law. Since 1999, the Canadian Red Cross Society (CRCS) has been independently monitoring immigration detainees held in IHCs and provincial correctional facilities across Canada through non-funded arrangements. To meet the NIDF objective of creating a better and fairer immigration detention system, a reassessment of monitoring services was undertaken to ensure national consistency in monitoring activities. Based on the analysis, it was determined that the CBSA needed to contract third party monitoring services on a national scale.

On July 27, 2017, a two year contract was awarded to the CRCS to conduct up to 86 monitoring visits yearly to CBSA IHCs and core provincial facilities where the majority of immigration detainees are held, with focus on the most vulnerable detainees: individuals with medical and mental health conditions and unaccompanied minors. Additionally, the CRCS is responsible for verifying that the treatment of immigration detainees is in compliance with domestic standards and international obligations to which Canada is a signatory. The contract also ensures more evidence based reporting

on monitoring activities and allows for transparency through the publication of an annual report.

In addition, the CBSA has a protocol with the UNHCR on conducting site visits and interaction with refugee claimants or persons in need of humanitarian protection. The protocol allows both sides to discuss issues in a proactive manner, such as access to places of detention, regular visits, confidentiality and recommendations to improve detention conditions. The CBSA engages key stakeholders on detention issues on an on-going basis as part of the continuous process to improve Canada's detention system.

3.4 Governance on a Death in Custody

Upon notification of a death in custody, the AIRWG will engage relevant Regional Director(s) and/or Regional DGs. The AIRWG's initial focus is to guide regional management and the completion of a DDR that contain factual details of the incident. Should specialised lines of support be required, the AIRWG makes experts available to enable a comprehensive review and investigation. Upon receipt of the DDR, the AIRWG reviews the findings, other relevant documents and the regional MRAP. The group then assesses whether national policies, procedures, guidelines and/or directives had been followed relative to the case under review and what improvements, if any, may be required. This assessment is delivered in the form of an HQ After Incident Report (AIR) and associated Management Response Action Plan (MRAP) to address recommendations to the AIR. The HQ report is then presented to the Incident Management Working Group chaired by the Vice-President of Corporate Affairs Branch for review, consideration and direction. This group ensures full implementation of the MRAP, and reports directly to the President.

3.5 Governance of Detention Program

To ensure appropriate governance of detention cases, in 2017 the Agency introduced a mandatory governance framework for the management and review of Long-Term Detention cases (99+ days in detention). At a minimum each region must convene monthly meetings to review cases held in detention for 99+ days. This committee consists of various director and manager level participants whose objective is to review individual case progression and determine necessary action if warranted. On a quarterly basis, each region is to engage the Regional Director General in their review. On a semi-annual basis, a mandatory review of all National LTD cases is undertaken by the Enforcement and Intelligence Operations Division (EIOD) and a report summarizing observations is submitted for consideration to the Executive Committee. This process provides objective and independent review of national detention cases to ensure appropriate progression of cases through the immigration continuum and to seek alternatives to detention where appropriate.

4.0 Developments since the Incident

4.1 Initial management guidance and direction – Oversight of Detention Decisions

On December 14, 2017, the DG of Enforcement and Intelligence Programs Division (EIPD) and EIOD issued a joint directive to all Ports-of-Entry (POE) and Inland Enforcement staff on the NIDF. It accentuated the impact and significance of a detention decision and placement; highlighted the rigour required in documenting a detention decision as well as record management practices. It further articulated efforts underway to enhance policies related to the NRAD and Detainee Medical forms, with training underway with a view to have all Inland Enforcement Officers trained by March 31, 2018.

4.2 Subsequent management guidance and direction – Oversight of Detention Decisions

On December 21, 2017, a second directive was disseminated by the aforementioned DGs to Regional DGs that underscored the active role of Chiefs (FB07 at POEs) and Inland Supervisors or Managers (FB05/FB06) in the oversight of detention and detention placement decisions, e.g. their authority to review and approve all detention decisions that lead to admittance to a detention facility. The review made under Section A55 may result in two outcomes: 1) the reviewer **concurs** with the decision to maintain detention/admit the individual to a detention facility; or 2) the reviewer **disagrees** with the decision and **renders a new decision** under Section A56 to release the individual. The direction also prescribed that detention placement shall default to an IHC where risk can be mitigated, and that the presence of criminality and/or suspected medical and/or mental conditions shall not automatically send an individual to the province. Officers shall consult with the IHC officer or manager for questions about risk mitigation.

On February 7, 2018 further clarification was sent to Regional DGs lowering the mandatory review for POE cases, to an FB05 Superintendent from the previous FB07 Chief.

4.3 Detentions Oversight and Governance Action Plan

To augment the above, a *Detentions Oversight and Governance Action Plan* was developed and is currently in effect until ~~fall~~ ~~August~~ 2018. The plan is co-sponsored by HQ Detentions Transformation and Program Management and Inland Enforcement Operations and Case Management Divisions, and comprises of four key activities with timelines, as follows:

1. Review of Detention Decision Making ~~(June 2018)~~
2. Review of Current Detainee Case Load ~~(March 31, 2018)~~
3. Review of Long-Term Detainee Management ~~(June 15, 2018)~~

4. Review of training and tools related to arrest, release, continued detention decisions ~~(August 29, 2018)~~

5.0 Key Observations and Recommendations

The following key observations and recommendations are based on the *In-Custody Death Due Diligence Report on* and discussions stemming from the HQ After Incident Review Working Group. The ~~MRAP~~ Recommendations for the DDR, developed by Greater Toronto Area and Southern Ontario Regions relate primarily to the following:

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1. A Review of All Arrest Files and Standardized Forms in the GTA and SOR regions
2. Engagement with the MCSCS on A59, A142 and A143
3. File Documentation and Maintaining the use of Detention as a Strategic Tool
4. Clarify and Review of Communication Protocols with MCSCS

Observation #1:

Despite established detention Memoranda of Understandings (MOU) with provincial partners and policy and operational guidance within CBSA Enforcement manuals, the following policies and procedures remain unclear and therefore lead to inconsistent use and application:,

- When and how outstanding immigration warrants are to be executed for individuals that are detained under a different Act of Parliament;
- When a detention order is to be issued against an individual who is arrested and in detention under a different Act of Parliament;
- How detainees are to be delivered into CBSA custody (at the expiration of their terms of court hold); and
- The use and application of section A59 of the *Immigration Refugee Protection Act (IPRA)*, which relates to incarcerated foreign nationals and/or permanent residents. More specifically the transfer of inmates into CBSA custody at the end of their period of detention under a different Act of Parliament.

Recommendation #1: **CBSA NHQ to fully examine policies and operational protocols related to the issuance of a warrant and a detention order for an individual incarcerated under another Act of Parliament. Further explore the use of A59 and its use and application across Canada. Identify policy gaps that may be addressed through revised guidance to the field. Identify whether this review will have impacts and require amendments to MOUs with provincial partners.**

Observation #2:

According to the DDR, there appears to have been no involvement by a Detention Liaison Officer (DLO) in this particular case. A DLO effectively serves as a liaison between provincial detention centres and the CBSA, particularly for cases where safety and security, behavioural, medical and/or mental health issues require intervention and/or impact a detainee's ability to participate in the *IRPA* enforcement process. The Detention Liaison Officer's (DLO) role is to support individuals who are detained under the IRPA held in provincial correctional facilities, through regular contact with detainees. The DLO will be the main CBSA contact for detainees, as well as for staff and management at detention facilities. This officer will be responsible for knowing who is on immigration hold at all times and ensuring these individuals have regular and meaningful contact with the CBSA throughout their period of detention.

DLO job functions include but are not limited to:

- Providing appropriate provincial detention centre staff with general information about the CBSA and the *IRPA* enforcement process;
- Providing information and advice to provincial detention centre officials about detainees held in their institution; such information includes the analysis of individual detainee's case work and information related to departure and removal arrangements;
- Ensuring medical and psychiatric assessments are being communicated (as required and when possible) between the different provincial detention facilities and the CBSA in cases where there is a need;
- Facilitating information sessions for provincial detention centre officials, when necessary, in order to enhance the understanding of the CBSA's processes and obligations, and provide education on the inland enforcement continuum and how the Agency deals with detained persons;
- Communicating with provincial detention centre management and try to resolve any issues regarding any complaints from detainees (i.e. food, dietary requests, Human Rights issues, medical services, living conditions, personal needs, hunger strikes, etc.);
- Identifying and report detainee issues including complaints, assaults, injuries and/or other serious incidents to the Manager or Director responsible for the delivery of the Detention Program in the region; and
- Providing advice, guidance, and exchange information with other areas of the Agency (primarily removals and hearings officers), law enforcement partners, detainees, their representatives and families (where appropriate), and non-governmental organizations, as required.

Recommendation #2:
Finalize drafted DLO position profile and functions and ensure consistent national implementation.

Observation #3:

Since detention should be used as a measure of last resort, mitigating measures should be found when an individual is part of a process that has no foreseeable enforcement outcome (e.g., likelihood of removal). Additional consideration to where an individual is in the immigration process and how this may impact the CBSA's ability to achieve an enforcement outcome, should be further clarified and evident in officer decision-making.

Recommendation #3:
ENF 20 to be revised to clarify the use of detention and its linkage to the CBSA's ability to achieve an enforcement outcome. In addition, ENF 7 should be updated to ensure there is supplemental guidance pertaining to the importance of effective note-taking and documentation for investigations and arrests.

Observation #4

Despite the existence of a viable ATD program provided by the Toronto Bail Program (TBP) in the GTA, current program parameters preclude the participation of individuals who are not subject to a removal order. In this particular case, the individual was subject to an outstanding admissibility hearing, therefore she was not subject to a removal order. As a result, she was not eligible for ATD programming based on administrative eligibility criteria. With the expansion of ATDs across Canada and the engagement of the TBP under a new contract (effective April 1, 2018), individuals should not be inadvertently disqualified from participating in a viable ATD program, where one is available and where the individual would otherwise be a suitable candidate. In line with the legislation, the CBSA must ensure ATDs are considered for all individuals regardless of an individual's status in Canada or point of processing on the immigration enforcement continuum.

Recommendation #4:
As part of the NIDF, the new ATD Framework should include clear eligibility parameters that are inclusive of all populations that may be subject to a detention decision.

Observation #5

Regional management oversight of detention files appears to be limited. In addition to the LTD Governance Process (January 2017), the Detention oversight and governance directives (4.1 & 4.2) and the finalization of a joint EIOD/EIPD Detention governance Action Plan (4.3) moving forward oversight should be improved at the stage of initial detention decision, where that decision will result in a transfer of a detainee to an

admitting facility. Despite these efforts and protocols, continual regional quality assurance processes should be enacted to ensure notes to file and required documentation is readily available and accessible, and completed in accordance with national policies. A national Quality Assurance Program (QAP) should be developed to ensure national oversight of all detention decisions and national adherence to policies.

Recommendation #5:
Develop and implement a national detentions QAP to improve program integrity that would lay the groundwork for policy guidance and protocols through regular QA reviews by regional management and the CBSA's NHQ.

Observation #6

When an officer is making a detention decision, they must weigh the factors associated with that specific case against the risk the individual may pose if released to the community or the risk of them failing to appear for future immigration processes. Consideration for vulnerabilities such as mental health are critical to making an informed decision. Policy directives articulate the necessity to consider vulnerability factors and the impacts that detention may have on an individual's mental health. This is further evidenced through the completion of the NRAD and Detainee Medical forms, which are mandatory forms that officers are to complete upon transfer to an admitting facility. It is not evident how vulnerability factors were weighed in this particular case against the decision to detain and the detention placement decision. Additionally, there was lack of awareness of the new IHC admissions criteria outlined in a memo by the Director of EIOD, GTAR (May 15, 2017), that was inadvertently not sent to SOR (Inland Operations and POEs). Of note, the IHC admissions criteria will become null/void upon the implementation of the revised NRAD on February 12, 2018.

Recommendation #6:
~~Establish a QAP and u~~**Update current products such as forms and manuals to ensure that vulnerability factors, such as mental health, are considered when determining if a detention is warranted. This should also be considered when determining the most appropriate facility/placement for detention and if continued detention is necessary.**

6.0 Conclusion

The recommendations above are intended to close any gaps in national policies and guidelines that may persist. Should the Agency concur, the recommendations and the MRAP will be implemented in 2018-19.

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Annex 1: *Management Response Action Plan (to the AIR and DDR)*
Annex 2: Regional *Due Diligence Report*